



Auckland District Health Board
Responses to the
2017/18 Health Select Committee Review Questions | 2019

Welcome *Haere Mai* | Respect *Manaaki* | Together *Tūhono* | Aim High *Angamua*

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Auckland DHB: an overview

Auckland District Health Board (DHB) is the Government's funder and provider of health services to the 530,000 plus residents living in the Auckland district. We are the largest health research and training organisation, the fourth largest by population and largest by income. We are one of the fastest growing, DHBs in the country, expecting more than 98,000 extra people in the next seven years.

Auckland has a similar deprivation profile to New Zealand as a whole. Almost one in five of our population live in the areas of the two lowest deciles and 23% in areas of the two wealthiest deciles.

Approximately 11,000 people are employed by Auckland DHB making us the city's largest business and our budget in 2017/18 was \$2.2 billion.

The DHB is responsible for the health of the population who live within the district. We provide a range of services ourselves as well as funding other services outside of our own facilities, including primary care and other community-based providers. We also work with a number of other organisations such as Auckland Council to improve outcomes for our population.

As an organisation, Auckland DHB provides hospital and community services from multiple sites including Auckland City Hospital, Greenlane Clinical Centre and the Buchanan Rehabilitation Centre.

We provide community child and adolescent health and disability services, community mental health services and district nursing. We are the northern region's provider of some specialist tertiary services e.g. cardiac surgery and radiation oncology services. We also provide specialist services not available within other DHBs including organ transplant services, specialist paediatric services, epilepsy services and high-risk obstetrics.

In addition to this, Auckland DHB also hosts Auckland's regulatory public health agency (Auckland Regional Public Health Service) to support delivery of their health protection, prevention and promotion services.

Key highlights for 2017/18

Auckland DHB has one of the healthiest communities in New Zealand and we have performed well against our key indicators in 2017/18. We made progress against the national Health Targets, achieving four of the targets in quarter four, and we achieved a financial surplus of \$1.0m.

Our other achievements in 2017/18 include:

- The life expectancy of our population is higher than for New Zealand as a whole and the gap between ethnic groups is decreasing – life expectancy for our Māori population has increased by 4.6 years over the last decade
- Our smoking rate is the lowest in New Zealand
- We achieved 100% against the Raising Healthy Kids Health Target in Q4, meaning all children identified as obese were referred for further help.
- We achieved the target a year early and have maintained 100% for all of 2017/18
- We achieved both the Better Help for Smokers Health Targets in primary care patients and pregnant women
- Our amenable mortality rate is among the lowest in New Zealand
- Auckland DHB has the highest 5-year cancer survival rate in New Zealand and we achieved the Faster Cancer Treatment target over the full 2017/18 year
- We delivered 17,321 elective surgeries, an increase of 3% on last year
- Most inpatients rated their care as very good or excellent, and our average score in the HQSC inpatient survey has improved to 8.8 (out of 10).

Our achievements in 2017/18 highlight our efforts to make a real difference for our patients, families/whānau and communities. This year we have continued to implement initiatives that maximise the value for available resources, improve the health of our populations – including a specific focus on addressing inequity – and enhance the quality, safety and experience of the care we deliver.

We have also worked to implement a wide range of initiatives that will improve the wellness, financial capability, engagement and career potential of our employees and supported a number of initiatives to improve collaboration across the regional health system.

Quality, safety and experience of care

In 2017/18 we also saw improvements in our performance in the Health Quality and Safety Commission (HQSC) inpatient survey.

The HQSC inpatient survey rates patient experience across four domains: communication, coordination, partnership, and physical and emotional needs. It is anticipated that this measure will provide new information about how people experience health care, how integrated their care is and may highlight areas that we need to have a greater focus on.

Our average scores have improved since the survey was implemented and are similar to New Zealand as a whole. For patients treated in May 2018, our scores were: Communication 8.5; coordination 8.7; partnership 8.9; and physical and emotional needs 9.0.

In 2017/18 we also increased our Patient e-portals are secure online sites provided by GPs where people can access their health information and interact with their general practice. Using a portal, people can better manage their own health care.

The use of patient portals is associated with improvements in patient-provider communication and an increase in patients feeling that they were able to take a more active role in medical decision-making. For those with a chronic illness such as diabetes, patient portals can also provide a vehicle to receive on-going self-management support.

At the end of March 2018, 61% of Metro Auckland practices had an online portal and 19% of all PHO registered patients had signed up for access – exceeding our goals for the year.

Auckland District Health Board is leading the way with youth friendly, confidential, and easy to access health services, based in high schools. Locating free health services in schools improves access to health care services for students by reducing some of the barriers to health care such as lack of transport and cost.

In 2017/18 10 secondary schools and five Alternative Education and Teen Parent Units receive DHB funded student health services. This means a nurse is available at school, supported by a visiting general practitioner. Nurses and GPs alike are youth specialists, experienced and qualified in the area of youth health.

As well as assessing overall physical health, nurses ask about home, education/employment, eating, activities, drugs and alcohol, suicide and depression, sexuality and safety (HEEADSSS) with young people. Any unmet physical, mental or sexual health issues are identified. Students can then be treated or appropriately referred.

In 2017 we provided HEEADSSS assessment to 99 per cent of the students in our school based programme.

Health and equity for our population

Auckland District Health Board has a long-standing commitment to working with mana whenua and mata waka to accelerate Māori health gain and eliminate inequities. To this end, Auckland and Waitemata DHBs have a Memorandum of Understanding with Te Rūnanga o Ngāti Whātua to support their participation in the governance, planning, funding, research and monitoring functions of our District Health Boards. Te Rūnanga o Ngāti Whātua has strong links with Māori communities across the Auckland DHB population.

As partners we are committed to working in prioritised locations to support solutions that are reflective of the needs and desires of our community. In 2017/18 Te Rūnanga o Ngāti Whātua contributed to the content of our Māori health plan. Their partnership with us ensures support for engagement of other key stakeholders for increased Māori health gain.

Our partnership activities also focus on the ways in which we can address the determinants of health and wellbeing in our communities.

Kainga Ora is a free Healthy Homes Initiative funded by the Ministry of Health to help low income families live in warm, dry healthy homes.

The shortage of affordable housing in Auckland has led to more families living in crowded, poor quality housing. Cold, damp, crowded homes contribute to recurrent and chronic respiratory illnesses, as well as preventable conditions, such as rheumatic fever and skin infections.

Our health professionals refer patients in our community (particularly children aged 0–5, young people with rheumatic fever, pregnant women and new mothers) to the service so that they can access help with insulation, ventilation, heating, carpet, curtains and repairs. Help can also come in the form of education and social support.

We are also working to ensure that the youth in the broader Auckland population are healthy, safe and supported by focusing on sexual and reproductive health, specifically on chlamydia screening with a focus on testing during pregnancy. Chlamydia is the most commonly reported sexually transmitted infection in Auckland, with the incidence highest in young people. Carriers often have no or non-specific symptoms. Left untreated, chlamydia in pregnancy can be passed on to the baby at delivery.

In 2017, 12.2% of all 15-24 year old Māori and Pacific youth living in Metro Auckland were tested for chlamydia (9,632 people).

This year Auckland DHB's PHOs have also been working to encourage Māori, in particular men aged 35-44 to come and get their cardiovascular disease risk check (CVDRA).

The Practice Network Team at Alliance Plus PHO initiated an incentive programme with their general practices. The scheme provided Rebel Sport vouchers for Māori males aged 35-44, who visited their GP for a CVDRA check.

Many of those missing out on risk assessment are in the very difficult to reach population – often those with a complete lack of contact details in the practice system. In light of this, a targeted approach was adopted including visiting local Marae, targeting Māori men, to get base line recordings of cholesterol and blood glucose levels.

At the end of June 2018, 89% of all eligible Māori had received a CVDRA check in the last 5 years, narrowly missing the 90% target. Also within the same time period, 1,727 Māori men aged 35-44 had been checked - 76% of the eligible total.

We have also been working to improve communication across cultures this year as health literacy has been identified as a barrier to accessing healthcare for some high needs population groups.

To address this barrier practice staff at Auckland PHO are required to complete CALD (Culturally and Linguistically Diverse) training. This training helps health care professionals communicate and interact effectively with people of different cultures.

We have also worked to remove barriers to weight loss surgery. In 2015 we began a programme of work with Waitemata DHB to develop a standardised approach to bariatric surgery and improve access for Māori and Pacific people.

An audit identified that attrition rates were significantly higher for Pacific people than other ethnicities, with more than 70% of Pacific patients referred not completing surgery.

We consulted with Māori and Pacific people who have been engaged with bariatric services, to better understand their experiences and identify areas for improvement. The consultation feedback and audit results helped drive several service improvements.

Early indications from the latest data show that the attrition rates for Pacific and for Māori patients have substantially reduced and are now similar to non-Māori non-Pacific rates. This means that more people are being supported to successful completion of surgery.

In 2017/18 68 people received bariatric surgery at Auckland DH, and of these 37 were Māori or Pacific.

Value for public health system resources

We have a number of programmes underway to reduce the volume of people presenting acutely to hospital, such as point-of-care testing in rural GPs, after-hours arrangements, and Primary Options for Acute Care (POAC).

Primary Options for Acute Care (POAC) is a service providing healthcare professionals access to investigations, care, or treatment for patients in the community, preventing an ED attendance and possible hospital admission, and assisting earlier discharge. PHOs worked together with the POAC team to support GPs to better utilise POAC. 2017/18 saw 6,028 patients referred to POAC, substantially meeting our target, and an increase of nearly 1,000 on the previous year.

Optimising patient flow within our hospitals, including reducing delays to diagnostic and treatment procedures, improves patient outcomes and reduces wasted bed days. For those admitted to hospital with ACS - acute coronary syndrome (e.g. unstable angina or heart attack) – it is important to perform coronary angiography quickly. In 2017/18, 657 ACS patients living in the Auckland DHB district received an angiogram, 89% within 72 hours, exceeding the 70% target.

A new model of x-ray service delivery on Great Barrier Island was also developed for patients who present with suspected uncomplicated fractures. X-rays are now performed on the island and sent to Auckland DHB for near real-time review by the radiology department. Specialist advice is then provided back to GPs on the island to support community patient management and avoid the need to transfer the patient to Auckland City Hospital.

Auckland DHB staff provided training to two nurses from Aotea Health on how to use the newly upgraded x-ray machine and the Auckland DHB radiology IT systems.

We have also established Point of Care testing (POCT), diagnostic testing where the analysis of the result is carried out near the patient (e.g. in a GP surgery) rather than being sent to a laboratory, for our rural general practices. POCT in these practices provides rapid results to assist clinical diagnosis and decision making and also reduces unnecessary emergency department presentations and/or hospitalisations.

Supporting our workforce to do our life's best work

In 2017/18 we implemented an employee engagement survey to track the baseline set in 2016. As we value and encourage employees' views and ideas, this has become a standard programme of work which allows employees to review and improve their workplace and team environment.

Our shared values of Welcome, Respect, Together and Aim High reflect what our staff and patients told us were important to them. We have begun to build on these with a culture initiative to hear and voice the stories of our people, when we and our collegial relationships are at our best. We have identified seven themes that touched all employees whether in one-to-one interviews, focus groups, walk-through galleries, drop-in centres or an organisation-wide survey. We are now working with our people to identify how they want the themes and supporting stories to be shared and utilised.

We also continue to take an active role in work at national, regional and individual DHB level to implement the State Services Commission's framework for Leadership and Talent Development across the health sector and continues to participate in the HWNZ Leadership and Management Workstream.

The Rangatahi Programme has been developed for Māori and Pacific senior secondary school students to facilitate Māori and Pacific student recruitment and retention in secondary school, tertiary education, and transition into the health workforce. It has been expanded to include the business side of health for non-clinical roles.

A+ Trust Scholarships continue to be provided for Māori and Pacific students undertaking their first tertiary qualification in health. The programme also aims to address workforce disparities by

increasing our Māori and Pacific health workforce and reducing specific skill gaps in the health and disability workforce.

The culture at Auckland DHB demonstrates care for all our people through these services. A particular spotlight has been shone onto our lower-paid workforce with the introduction of the 'To Thrive' programme.

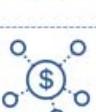
We also commenced work to receive the Rainbow Tick, making us the first DHB to do so. The Rainbow Tick provides us with a set of criteria to measure ourselves against and to demonstrate that we are an organisation that embraces diversity.

In 2017/18 we also retained a focus on our Speak Up - Kaua ē patu wairua (do not offend my spirit or my soul) programme, designed to support all employees to speak up when they experience, witness or are accused of bullying, discrimination or harassment goes from strength to strength. A 40-strong group of Speak Up supporters has been formed and continues to support victims and accused alike. The programme and the supporter group are both clinician led.

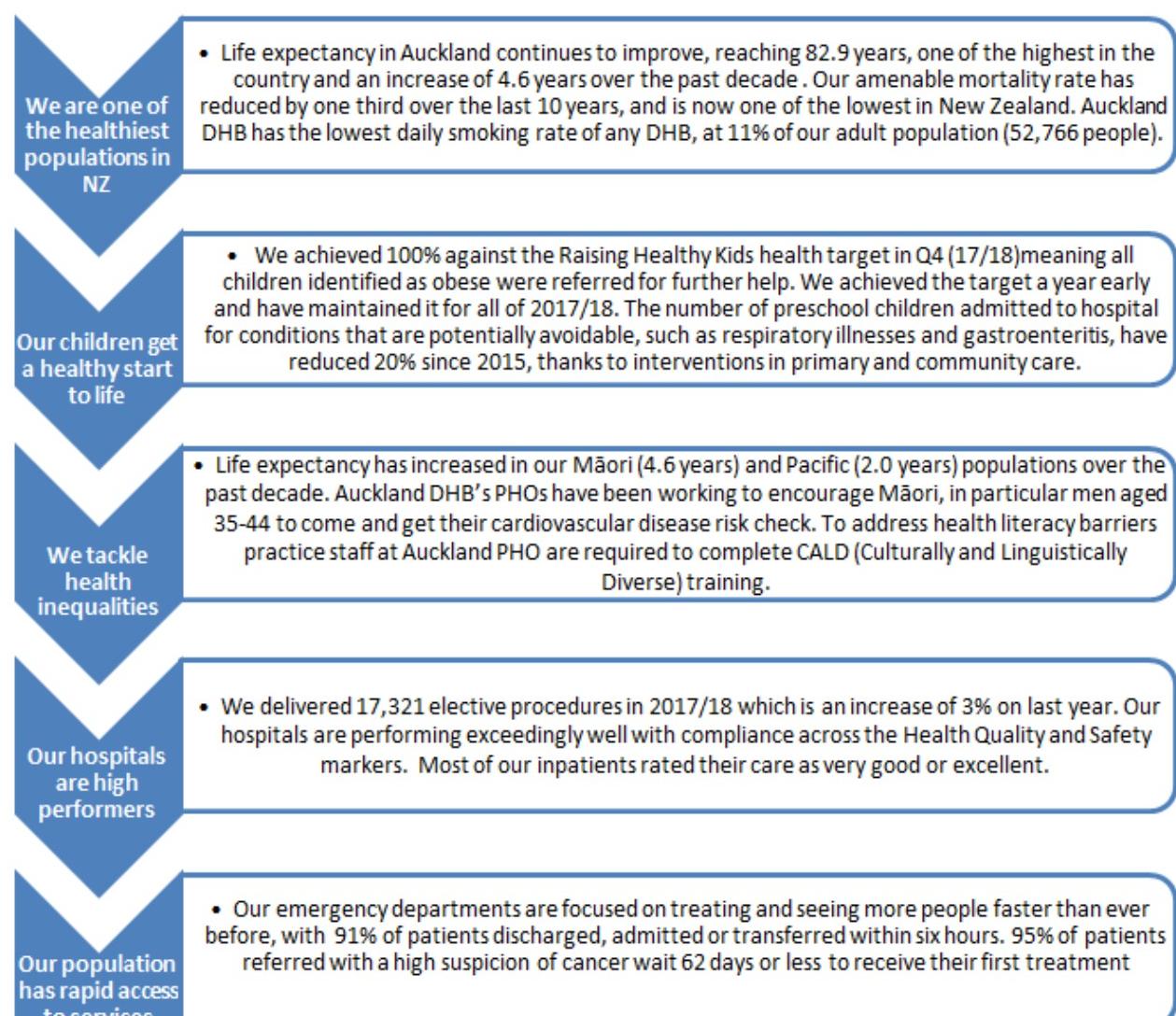
A huge programme of work, Security for Safety, has focused on ensuring employees are safe and secure at work, with work streams focusing on all aspects of safe working, from security ID, CCTV to a culture of keeping self and colleagues safe, including online training.

A well-researched and direct correlation between an employee's wellbeing and patient safety and wellbeing has also led the DHB to establish a Wellbeing Steering Group to manage the numerous initiatives that sit under the banner of wellbeing. These include a Mindfulness-Based Stress Reduction (MBSR) programme in Mental Health Services, the World Health Organisation (WHO)'s Five Ways to Wellbeing, a kindness and compassion programme under which Auckland DHB has become Australasia's first Schwartz Centre hospital, with more to come.

Snapshot of our impact

Our population		Our Organisation	
	We are the fourth largest, and one of the fastest growing, DHBs in the country. More than 530,000 people live in the Auckland DHB district. By 2025, our population will have grown by 98,000 extra people		Auckland DHB employs around 11,000 staff making us the largest employer in Auckland city.
	We have an ethnically diverse population with 8% Māori, 11% Pacific, 34% Asian and the remainder European/Other		Our budget in 2017/18 was \$2.2 billion
	The Auckland DHB Māori population is younger, with 48% less than 25 years (15,075 young people) compared with 33% of non-Māori.		Our major facilities are Auckland City Hospital, Starship Children's Hospital, Greenlane Clinical Centre and Buchanan Rehabilitation Centre
	Auckland DHB has the highest estimated PHO enrolment coverage for Pacific peoples in the country		We are the largest trainer of doctors and a national leader in clinical research with 1,200 active projects
	When compared nationally, Auckland DHB has a higher proportion of our population identifying as Asian. By 2033, the Asian population is		We provide specialist services including organ transplant services (heart, lung and liver), specialist paediatric services, epilepsy surgery and high-risk obstetrics
			We have 1,188 inpatient and day surgery beds, 41 theatres and provide care to

Snapshot of our impact



Our vision

Our vision is Healthy Communities, World-class Healthcare, Achieved Together. This means we are working to achieve the best outcomes for the populations we serve, people have rapid access to healthcare that is high quality and safe and that we work as active partners across the whole system with staff, patients, whānau, iwi, communities, and other providers and agencies.

Our district health board has built a firm foundation for supporting good health and for providing quality health services. We are proud of this role and aspire to the consistent delivery of world-class care. We will do more to up skill our workforce so staff can work in more people-centric and patient-centric ways.

Our strategic themes outlined below provide an overarching framework for the way our services will be planned, delivered, and developed to deliver our vision. Our values shape our behaviour and describe the internal culture that we strive for.



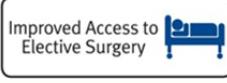
Our Growth

Auckland DHB has undergone steady growth over the last year as illustrated in the table below. The growth in elective surgery volumes we have delivered demonstrates the positive interventions we have made in the lives of our patients supporting improved health outcomes and productive and independent lives.

		Jun-17	Jun-18	Increase/ Decrease	% difference
Population	Total	515,000	531,000	16,000	↑3%
	Life Expectancy	82.7	82.9	0.2	-
Staffing	Total Staff (Headcount)	10,367	10,846	479	↑4.6%
	Total Staff (FTE)	8,200	8,769	569	↑6.9%
Outputs	Elective Surgery volume (provider)	16,822	17,321	499	↑3%

Our Performance

2017/18 was a year of impressive achievements for our DHB. Focus on key areas of service delivery and sustained efforts with our primary care partners have had positive impacts on our performance. Results below show the quarter four result, and full year's performance, where relevant. For quarter four we achieved four of the seven health targets.

Health Targets		Target	Q4 2017/18	Full Year
 Shorter Stays in Emergency Departments	95% of patients admitted, discharged or transferred from an emergency department (ED) within six hours.	95%	91%	91%
 Improved Access to Elective Surgery	An increase in the volume of elective surgery by an average of 4000 discharges per year ¹	17,881	n/a	17,321 (97%)
 Faster Cancer Treatment	90% of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment ²	90%	91%	95%
 Increased Immunisation	95% of eight months olds will have their primary course of immunisation on time.	95%	94%	94%
 Better Help for Smokers to Quit	90% seen in primary care provided with advice to quit 90% of newly registered pregnant women provided with advice to help quit	90% 90%	92% 92%	92% 97%
 Raising Healthy Kids	95% of obese children identified in the B4SC programme will be offered a referral to a health professional ³	95%	100%	100%

Research and Development

Having an excellent programme of research distinguishes great hospitals. Auckland District Health Board is the largest tertiary care centre and the largest clinical research facility in New Zealand. Our research portfolio comprises over 1,200 projects and our doctors, nurses, allied health professionals and scientists engage in research that attracts funding, participation and peer esteem both from New Zealand and internationally.

Auckland DHB's hospitals are teaching hospitals and partners with the University of Auckland in an Academic Health Alliance. The goal of the alliance is, to deliver research-informed healthcare alongside clinical teaching and training, will fast-track translation of research findings from "bench to bedside", and onwards to communities and families.

Our research efforts attract funding from more than 100 sources, including public funds, private foundations and commercial sponsors worldwide

¹ Auckland DHB's targeted increase (share of the New Zealand total additional 4,000 discharges) is 651 additional discharges; quarterly results are year to date.

² This result does not include patients that have not yet received their first treatment. If a patient has waited more than 62 days as at the reporting date, he/she will not be reported as a breach because the first treatment has not yet occurred.

³ Quarterly results are for checks completed in the rolling 6-month period ending one month prior to the end of the quarter, as per MoH definition. The FY result is for the 12-month period Jun 2017 to May 2018 (thus the Q1 result is only partly represented in the FY result).

We recognise the value of research for informing clinical practice and improving health outcomes, and we promote and adhere to the principles of ICH-GCP guidelines. Our human subject protection programme is accredited to receive US federal research funding.

These combined capabilities attract expert clinical staff and promote an academic approach based on the highest ethical standards and focused on applications that improve health outcomes.

Living Within Our Means

We have lived within our means for the past five years, and in 2017/18 posted a surplus of \$1M.

	Revenue (\$,000s)		Expenditure (\$,000s)		Surplus / (Deficit) (\$,000s)	
	Budget	Actual	Budget	Actual	Budget	Actual
2013/14	2,002,598	1,863,610	2,002,513	1,863,358	85	264
2014/15	2,056,884	1,917,219	2,056,857	1,917,066	27	355
2015/16	2,032,943	2,049,732	2,030,577	2,046,861	2,367	2,871
2016/17	2,125,222	2,079,356	2,120,718	2,076,195	4,504	3,162
2017/18	2,127,039	2,121,626	2,197,909	2,192,419	0	1,013

National and Tertiary Services

We provide emergency, medical, surgical, maternity, community health and mental health services. Auckland DHB is unique in that we provide specialist services not available in other DHBs. We are New Zealand's largest provider of specialised tertiary services. More than half the work done within our hospitals is for people who live outside Auckland City. This is a much higher proportion than any other DHB.

Auckland DHB is the regional provider for kidney transplantation, neurosurgery, cardiothoracic surgery, ophthalmology, most paediatric surgery, gynaecological oncology and the hub of the regional cancer network.

In addition to this we deliver the majority of the nationally funded personal health services. This includes the following services:

- Paediatric Cardiac and Adult Congenital Services
- Heart and Lung Transplants
- Paediatric Intensive Care
- Paediatric Metabolic Services
- Liver Transplants
- National Genetics service
- Complex renal transplants

Auckland DHB regularly receives referrals for the management of complex patients from the other Tertiary Centres. We are on occasion the provider of last resort for some tertiary services. Tertiary and quaternary services are essential but expensive - As a hospital of last resort; we carry the greatest burden for the cost of specialist work.

Health Select Questions

- 1.** What restructuring occurred during 2017/18 and each of the previous four financial years? Please provide copies of any evaluations carried out prior to restructuring and details of the structural change; the objective of restructuring; staff increases or reductions as a result; and all costs associated with the change including costs of redundancy.

Response to Question 1

Auckland DHB is continually evaluating the way in which our services are provided to ensure the best quality care is delivered to our community and that this care is provided effectively and efficiently. There have been a number of changes some of which have involved service model and employee restructuring programmes. Staffing levels have increased year-on-year over this period including the numbers of frontline staff in response to demand in current services and as new services have been created (e.g.: CDU etc.). Some positions have been disestablished which have resulted in redundancy payments but the overall effect has been a net increase in the (predominantly) clinical workforce. This reflects our intent to ensure resources and staffing models respond to the health priorities of the community.

We have a standard approach to reviewing services which involves a proposal for change in line with legislative expectations, and includes consultation and feedback from our Union partners, affected employees and internal/external stakeholders. Proposed changes that have the potential to materially impact on staffing structures, resourcing or service delivery of the organisation are presented to the Executive Leadership Team and the Board before consulting with the relevant groups. Final decisions are made after full stakeholder consultation.

The costs of redundancies are provided below. However the flow-on costs of services provided by human resources, learning and development, occupational health and safety, recruitment and a number of external organisations, including employee assistance and outplacement services, have not been included.

Change management processes occurring 2017/2018

Structure reviewed/changed	Purpose	Staff increases or reductions	Redundancy costs
August 2017 Perioperative Directorate	Proposed introduction of the Clinician Leadership Model and Management of Services in the Directorate.	Creation of 6 new roles and the disestablishment of one. 10 roles had changes in title, reporting line and/or job description.	Nil
August 2017 Central Sterile Services Department (CSSD)	To support the implementation of a service that provides reliable, efficient and consistent support for its customers to ensure patient safety and to achieve organisational excellence.	Creation of 10 new roles totalling 9.6 FTE. No roles were disestablished although some had changes in designation, reporting line and/or job description.	Nil
June 2018	Address workload demands and resourcing	8 new HR Consultant	Nil

HR Partnering & Management team	for both day-to-day urgent and complex work together with time to focus on delivery of the strategic people plan.	established 2 HR Advisor positions disestablished 1 HR Manager position disestablished	
September 2018 HR Services	To align some roles into the correct function	Nil	Nil
January 2018 Perfusion Unit Leadership	Originally team lead by Chief & Deputy Chief Perfusionists; Chief replaced by Perfusion Unit Manager; Deputy replaced by two leads for Adult & Paediatric	No increase or decrease in numbers of people; Service was sized.	Nil
August 2018 Cardio Thoracic Surgical Unit (CTSU)	Hospital Aide position replaced by qualified Health Care Assistant position	No increase or decrease	Nil
September 2017 Cardiology & CTSU	Increase number of residential doctors to meet the requirements of Schedule 10	Increase 3 RMOs	Nil
July 2017 CTSU Patient pathway – improve care coordination for whānau centred care	Change in key responsibilities for Charge Nurses & Nurse Specialists	Increase 0.5 FTE specialist nurse	Nil
October 2017 Auckland Regional Public Health (ARPHS)	Communications team transferred to Auckland DHB	No change in FTE	Nil
April 2018 ARPHS Communicable Disease Control (CDC) Team	Introduction of professional nursing component; redesign of responsibilities	No change in FTE number – replaced Nurse Specialist position with Nurse Consultant	Nil
July 2017 ARPHS Health Protection Team	Split large unsustainable team which encompassed several portfolios into two teams	Increase number of managers by one	Nil
October 2017 and March 2018 Fertility Plus	Align team structure with strategic objectives and challenges Administration review - new management	Increase by one FTE	Nil

	tool, weekend cover required for Clinics, additional FTE		
May 2017 Women's Assessment Unit	Review of work pattern to align with other clinics	No increase or decrease	Nil
July 2017 Clinical Support Services	Structural review and change to management level within Forensic Pathology & Laboratory Medicine	No redundancies. New position created at GM level. Current incumbent moved to a new position funded through Contracts Review.	Nil
February 2018 Patient Management Services	Review and structural change to management level.	No redundancies. Disestablished Patient Flow Manager, created new positions; Nurse Unit Manager, Operations Manager and Lead Trend care. Nurse Director new and additional cost.	Nil
March 2018 Commercial Services	Review of Commercial services.	Operations Manager Procurement & Supply Chain position disestablished.	\$37,033
Sexual health CLTC	Revised model of care was implemented in Sexual Health Services in July 2015 following a review led by the three Auckland Planning and Funding Team. Change included service sizing to ensure the workforce matched the demand.	Reduction in the SMO/MO workforce in the sexual health service & and increase in SMO/MO for sexual assault service. Creation of three new roles: Nurse Practitioner, HCA and Lead Clinician for Sexual Assault. Alignment of the registered nursing workforce with the demand. Alignment of clinics with patient demand, resulting in a decrease of clinics for satellite sites.	\$310,000
July 2017 Community - seven day service CLTC	Providing responsive seven day adult community services to support improved patient flow with timely discharges, enabling more people to avoid hospital admission,	A broader range of community services will be provided seven days a week in future. Introduction of a Duty Team Leader roster.	Nil

	improve patient and family experience.	New staff joining to be recruited on seven day contracts.	
Jan 2017 Community Introduce L3 roles. CLTC	Additional two level three Clinical Leadership roles reporting to the Service Clinical Director (SCD).	Introduction of two roles: Nurse Unit Manager & Allied Health Unit Manager	Nil
Community Review Locality structure CLTC	Redistribute portfolios and support frontline staff.	Introduction of new titles and portfolios but no new roles.	Nil
Palliative Care CLTC	Progress integrated Palliative Care Strategy	In 2018 a staffing mix of 3.1 FTE SMO and 8 FTE CNS/NP was implemented. The new staffing model will have 4 individual SMOs (total of 3.1 FTE).	Nil
Reablement Consolidation of Inpatient unit at Auckland hospital CLTC	Move Rehab Plus inpatient care to Auckland Hospital campus. Improve staff and clinical governance and integration of care within Reablement Services. Enhance staff education and learning. Ensure a sustainable, financial affordable staffing model. Support improvements in patient flow and a reduction in waiting times.	Reduce one Charge Nurse role and create a Nurse speciality role.	Nil
March 2018 Child Health Trauma Service	Correctly size function and increase clarity of roles	Reduce FTE by 0.5	\$22,300
May 2018 Child Health Transcription Service	Align practice across ADHB and ensure continuity of service	Centralise 2x transcription roles into Transcription team	\$62,500 (incl. retiring gratuity)
December 2018 Child healthAlliance NICU	Achieve alignment with Nursing Council of NZ requirements and ensure care is aligned with the	Headcount neutral, as change will be achieved by attrition	Nil

	appropriate scope of practice by transitioning NS Advanced Neonatal Practice workforce to Nurse Practitioner.		
August 2018 Health Intelligence Team	Following the findings of a review to improve the delivery of this team, including renaming the team and introducing new services.	5 senior manager roles and functions added	Nil
November 2018 Health Intelligence	Following on from the review, restructuring resources to align to service deliver model.	2 senior DA roles and 1 manager role disestablished 4 new roles created	\$11,008
August 2018 Health & Safety			

Change management processes occurring 2016/2017

Structure reviewed/changed	Purpose	Staff increases or reductions	Redundancy costs
July 2016 Allied Health Relocate Allied Health staff to Child Health Directorate	Strengthen Child Health Service and deliver efficiencies	No change to staffing numbers. (65 staff moved)	Nil
July 2016 Training roles for InterRAI centralised from DHBs into TAS	Cost and quality efficiencies for training tool used by multiple DHBs	Reduction of 1 role	\$21,406
September 2016 Cancer & Blood – Restructure of Faster Cancer Treatment Tumour Stream	Confirm the existing tumour stream coordinator roles and FTE. Amend job description and change reporting lines.	None	Nil
September 2016 Merger of Surgical High Dependency Unit into Adult Medical Department of Critical Care Medicine	To fully implement in DCCM the recommendations of the external service review.	Clinical Charge Nurse HDU disestablished and redeployed (1FTE) 10 nurses transferred to DCCM	Nil
December 2016 Community Services Leadership structure in Community & Long Term	Strengthen leadership support for 5 locality MDTs and enhance clinical governance	2 new roles established	Nil

Conditions Directorate			
May 2017 Allied Health Relocate Allied Health staff to CH Directorate	Strengthen CH Service and deliver efficiencies	No change Dietetics team (6 staff) moved	Nil
March 2017 Integrated leadership for Specialist Palliative Care providers	Increase integrated strategic planning between Auckland Hospital and Mercy Hospice for implementing ADHB's palliative care strategy	1 new role established (employed by Mercy Hospice and part funded by ADHB)	Nil
February 2017 Child Health Community Redesign	Redesign of Community Services to deliver ADHB vision re healthy communities	No additional staff but change of existing staff roles/reporting lines.	\$68,233.09
April 2017 Surgical Team Administration, Surgical Directorate	Review of staffing model and hours of work to deliver effective service	No additional staff but change of existing staff roles/reporting lines	Nil
April 2017 Adult Medicine – Neurology implementation of Hyper-acute Stroke Service	Introduce revised nursing model of care for the Stroke service meeting the increase in demand for skilled registered nurses to support patients on the Hyper-acute Stroke Pathway	Stroke Nurse Specialist redeployed. 10.5FTE RNs recruited. All nursing staff employed on 8hr shifts	Nil
June 2017 Ophthalmology Administration Support, Nursing & Allied Health, Surgical Directorate	Alignment of management structure to make service more efficient and able to respond to forecasted growth in demand	8 new roles established	Nil
June 2017 Introduction of 7 day working week for community services	Create access to home based community services across 7 days	Roster change required for majority of teams phased in over time	Nil
February 2017 Systems, Intelligence and Planning (SIPs) Team, Auckland Regional Public Health Service (ARPHS)	Realignment to strengthen emergency management capability	No additional staff but change of existing staff roles/reporting lines	Nil
June 2017 Health Protection Team, Auckland Regional Public Health Service (ARPHS)	Strengthen service effectiveness	1 role disestablished and 2 roles established	Nil
April 2017 Change of Work Pattern – Day Assessment Unit	Long standing work pattern did not reflect service requirements.	Change to reflect other WH clinics.	Nil

March 2017 Facilities & Development Org Structure	Realignment to ensure structure fit for purpose and future planning	2 disestablished, 7 established	\$11,475
February 2017 Information Management Operations Org Structure	Review to ensure structure fit for purpose and future planning	4 disestablished, 4 established	Nil
June 2016 Pharmacy Clinical Support Services	To align structure with modern medicines management strategy. Decision August 16	No change to FTE	Nil
May 2017 Strengthen Midwifery Clinical Leadership	Revise Model of Care for inpatient maternity areas with 24/7 designated senior midwife coverage	11 new Clinical Charge Midwife positions across 4 inpatient services	Nil
June 2017 HR Services Org Structure	Review to ensure structure fit for purpose and future planning	6 positions disestablished, 6 established	\$50,000

Change management processes occurring 2015/2016

Structure reviewed/changed	Purpose	Staff increases or reductions	Redundancy costs
May 2016 Child & Youth Mortality Review Coordinator	Reduction in Funding from Health Quality Commission	Reduced FTE from 0.7 to 0.4 (partial redundancy)	\$6,684.00
January 2016 Child Health – data admin	Reduction in numbers	1 x redundancy	\$1,480
September 2015 Dietetics	Deliver efficiencies through reorganisation	Reduction of 1 FTE	\$47,385
October 2015 Surgical Services Directorate	Strengthen service by Implementing clinical leadership model.	15 roles disestablished, 17 roles established, and changes to existing staff roles/reporting lines.	Nil
November 2015 CVICU, Cardiovascular Directorate	Clinical Nurse Coordination role introduced to strengthen nursing structure.	Role established to cover 24/7 shifts	Nil
September 2015 Pacific Quit Smoking Service, Auckland Regional Public Health Service (ARPHS)	MoH contract ceased.	5 roles disestablished	\$34,940

June 2015 Mental Health & Addictions (TWT)	Mental Health & Addictions org structure – structured into 6 service groupings	4 disestablished, 4 established	\$29,164
Creation of Learning and Development Centre	Implementation of review into L&D requirements	4 positions disestablished, 5 new positions created	\$74,965
September 2015 Ward 72 and 7A HCA Model of Care	Move from fixed shift patterns to rotating shifts across both wards	None – shift pattern changes implemented	Nil
July 2015 Senior Nursing Structure – AED/APU	Implement senior nursing structure to support the Nurse Unit Manager, integrate staff across AED/APU and provide focus on patient flow and improved care to patients.	2 new Charge Nurse positions created	Nil
December 2015 Introduction of Locality based multi-disciplinary teams	Increase connection with PHOs and strengthen community response for discharge and prevent readmissions	None – reporting lined changes only	Nil
August 2015 Child & Youth Mortality Review Coordinator	Reduction in Funding from Health Quality Commission	Reduced FTE from 0.9 to 0.7 (partial redundancy)	\$4,381
July 2015 Ward 68 HCA Model of Care	Implementation of flexible rostering - HCAs	None – shift pattern changes implemented	Nil

Change management processes occurring 2014/2015

Structure reviewed/changed	Purpose	Staff increases or reductions	Redundancy costs
Clinical Directors Structure - Women's Health	Strengthen service by Implementing clinical leadership	Reduction of 1 FTE	\$34,022
Operational Finance	New structure finance team to deliver efficiencies	Reduction of 3 FTE	\$16,814
Clinical Directors Structure – Child Health	Strengthen service by Implementing clinical leadership	No additional staff but change of existing staff roles	Nil
Clinical Directors Structure – Mental Health	Implement clinical leadership	No additional staff but change of existing staff roles Nil	Nil
Clinical Directors Structure – Community and Long Term Conditions	Strengthen service by Implementing clinical leadership	No additional staff but change of existing staff roles	Nil

Clinical Directors Structure – Adult Medical Services	Strengthen service by Implementing clinical leadership	No additional staff but change of existing staff roles	Nil
Clinical Directors Structure – Cardiovascular Directorate	Strengthen service by Implementing clinical leadership	No additional staff but change of existing staff roles	Nil
Clinical Directors Structure – Cancer and Blood	Strengthen service by Implementing clinical leadership	No additional staff but change of existing staff roles	Nil
Facilities Collaboration Auckland DHB / WDHB	Strengthen service by Implementing clinical leadership	Increase of 1 FTE	Nil
Contact Centre Collaboration Auckland DHB / WDHB	Implement joint contact centre to improve service delivery	Increase of 1 FTE	Nil

Change management processes occurring 2013/2014

Structure reviewed/changed	Purpose	Staff increases or reductions	Redundancy costs
Funding and Planning Collaboration Auckland DHB / WDHB	Implement joint Funding and Planning Team	Reduction of 2 FTE	\$101,972
Clinical records	Change in technology leading to efficiency	Reduction of 4 FTE	\$75,373
Auckland Regional Public Health	Reduction in staff	Reduction of 2 FTE	\$87,356
IMS	Alignment of structure to make service more efficient	Reduction of 1 FTE	\$31,116
Commercial Services	Reorganisation to deliver efficiencies	Reduction of 1 FTE	\$1,730
Non-Clinical Support	Reorganisation to deliver efficiencies	Reduction of 1 FTE	\$30,392

2. Was any work conducted around mergers with other agencies in the 2017/18 year? If so, for each such project, what agencies were being considered for mergers?

Response to Question 2

There have been no mergers of Auckland DHB with other agencies in 2017/18. The DHB continues to actively collaborate with other DHBs directly or through the existing vehicles of Northern Region Alliance, healthAlliance and New Zealand Health Partnerships Ltd.

3. Was any rebranding undertaken in the 2017/18 financial year? If so, what did the rebranding involve, how much was spent on rebranding, why was it undertaken, and was it carried out

internally or externally? What rebranding was carried out in each of the previous four financial years?

Response to Question 3

No rebranding was undertaken in the 2017/18 year. In the previous four financial year's one brand refresh was undertaken in 2014/15. This involved an amendment to the Auckland DHB logo and the development of consistent templates. The refresh was carried out internally and the refreshed logo was added to documents, signage and other materials only when it was time for a reprint or replacement, to ensure extra costs were not incurred.

4. Are any inquiries or investigations currently being undertaken into performance by any external agency? If so, please provide the following details:

- The body conducting the inquiry/investigation
- The reason for the inquiry/investigation
- The expected completion date

Response to Question 4

While Auckland DHB is the subject of investigations by statutory bodies such as the Health and Disability Commissioner and Ombudsman from time to time Auckland DHB is not currently subject to any inquiries or investigations in respect of the organisation's performance.

5. How many reviews, working groups, inquiries or similar does the department operate or participate in? Please list by title.

Response to Question 5

ADHB has not operated, or been a participant in, external reviews, working groups, inquiries or similar.

6. For each review, working group or inquiry, what is the estimated cost for 2018/19, 19/20, and 20/21?

Response to Question 6

Not applicable

7. For each review, working group or inquiry, what are the key dates and milestones including start dates, regular reporting dates, and end dates?

Response to Question 7

Not applicable

8. For each review, working group or inquiry how many departmental staff are involved by head count and by FTE?

Response to Question 8

Not applicable

9. For each review, working group or inquiry what reports, briefings or documents have been produced? Please list by title and date produced.

Response to Question 9

Not applicable

10. For each new spending initiative introduced over the last seven Budgets (i.e. Budget 2011, Budget 2012, Budget 2013, Budget 2014, Budget 2015, Budget 2016, and Budget 2017), what evaluation has been undertaken of its effectiveness during 2017/18 and what were the findings of that initiative? Please provide a copy of the evaluation reports. Where no evaluation has been completed, what provision has been made for an evaluation to occur and what is the timeframe for that evaluation?

Response to Question 10

NA

11. What new services, functions or outputs have been introduced in the last financial year? Please describe these and estimate their cost.

Response to Question 11

Raising Healthy Kids Health Target - PPAL

In response to the Raising Healthy Kids national Health target a Positive Parenting Active Lifestyle (PPAL) programme commenced in the 2018/19 in both Waitemata and Auckland DHBs. PPAL is a family-based, multicomponent lifestyle weight management service for preschool children and their whānau. The programme incorporates Group Lifestyles Triple P for parents/caregivers and an activity programme for their children. There are two providers covering Waitemata and Auckland DHB. The funding allocated to the Auckland DHB provider is:

- Establishment funding: \$39,500
- Annual 2018/19 funding: \$158,000

Hauora Tāhine (Transgender Health Service)

Hauora Tāhine (transgender health service) was expanded in the 2017/18 year. Provided by Counties Manukau Health for young people domiciled in the Auckland and Waitemata District Health Board areas, the service was expanded from senior medical officer and nurse time only, to include increased nursing time, clinical psychologist and administration, plus operational costs. The cost of the expanded service for the 17/18 financial year for Auckland DHB was \$171,000.

MMR Immunisation Programme for Youth

Due to the mumps outbreak in the Auckland region during the 2017, Auckland DHB and Waitemata DHB commissioned a targeted Mumps-Measles-Rubella (MMR) Immunisation Catch-up Programme, focussed on decile 1-3 secondary schools and alternative education units across the two DHBs' catchment area. The eligible population was approximately 13,000 students and the programme achieved delivery of over 5,500 vaccinations to predominantly Māori and Pacific young people who were either un-immunised or under-immunised. Auckland DHB budgeted \$304,000 for the programme; final costs will be available in 2019.

Auckland and Waitemata DHB Plunket Collaboration

In Quarter 4 2017/18 Waitemata DHB collaborated with Plunket to provide an additional outreach immunisation option one day per week, initially targeted for Māori babies turning eight months

during that quarter but extended in the later part of the quarter, to include Pacific and Māori babies turning eight months in Q1 2018/19. The cost of the service in 2017/18 was \$10,345. The cost recognises that Plunket provided a branded vehicle and health support worker for this one-day week collaboration at no cost to the DHB. Plunket and both Waitemata DHB and Auckland DHB have reached an agreement to continue this collaboration from October 2018 until 30 June 2019.

Antenatal Immunisation reminder cards

We have developed reminder cards to promote antenatal immunisation for pertussis (whooping cough) and influenza to pregnant women. Over 30,000 cards per vaccine were printed and distributed to midwives, pharmacies and GP practices across two DHBs. Consumer and provider feedback has been very positive and the cards were subsequently re-printed by other DHBs. The cost to Auckland DHB in 2017/18 was \$1,250.

Maternity Incentives Smoking Cessation Pilot

In 2018 Auckland DHB and Waitemata DHB funded an incentivised maternal and whānau (those living with a pregnant woman) smoking cessation pilot that has Māori whānau as a priority population; this was commenced in January 2018. Ready Steady Quit the stop smoking provider for the Auckland and Waitemata DHB area provides stop smoking support and nicotine replacement therapy over 12 weeks through their Ministry of Health contract. The DHB provides the funding for the incentives and QuickMist. Women can receive up to \$350 in vouchers if they are validated to be smokefree during their pregnancy and at two weeks post-partum, whānau can receive up \$200 in vouchers. The estimated cost for Auckland DHB in 2017/18 was \$8,400

Community Pharmacy Stop Smoking Services

Some pharmacies have been contracted to provide NRT and multi-session behavioural support, started January 2018. The estimated cost in 2017/18 for Auckland DHB was \$56,200.

Rural Point of Care Testing

The Rural Point of Care Testing Service was implemented in the first test site in December 2017 and was rolled out to DHB rural general practices before the end of April 2018. The Rural Point of Care Testing Service (R-POCT) is the first Rural Alliance project to be supported across both Auckland DHB and Waitemata DHBs. Providing Point of Care Testing (POCT) in rural general practices enables rapid decision-making from assessment and diagnostics to treatment, avoids unnecessary emergency department presentations and/or hospitalisations, and facilitates the provision of appropriate care at the right time, in the right place (whether that is at their general practice or by referral to hospital).

The diagnostic tests identified by the Rural Alliance using the services stocktake, as the most clinically valuable in the management of people presenting acutely unwell in the rural setting are supported. The service uses the POCT analysers to provide rapid results to assist clinical diagnosis either by ruling out conditions, confirming conditions or determining whether further investigations are needed, i.e. enabling the right management to be initiated sooner. The cost to Auckland DHB Rural Point of Care Testing (R-POCT) over 3 years: \$400,000.00 and Establishment of Rural Primary Options for Acute Care (Reimbursement of practice costs for R-POCT: \$12,000. The estimated cost in 2017/18 was \$154,000 establishment costs and \$80,000 opex cost.

Paired Up, Youth Peer Support Pilot Service

Paired Up is a peer led pilot support service located within Tamaki College, a decile 1 school in area of high need. Following two suicides at the school in 2017, Auckland District Health Board commissioned the pilot service to increase resilience and coping skills of youth at the school. The pilot has initially been commissioned for one year and includes an evaluation as part of service delivery. The evaluation takes place towards the end of 2018 and will inform future delivery and funding. The cost of the initial year of delivery and evaluation is \$165,000.00

Fit For the Future

Fit For the Future (FFtF) was a MoH funded pilot programme to build the evidence base for Primary Mental Health initiatives. ADHB was selected by the MoH as a pilot site. The pilot delivered a range of interventions designed to build a robust evidence base for services to meet the needs of people with mild to moderate mental health issues. This funded a large number of services within the primary care and community settings including Health Coaches, Health Intervention Practitioners (known as Behavioural Health Consultants internationally) and additional Awhi Ora hours which is an early intervention, low threshold support model which co-locates mental health NGO's within the primary care setting. These noted initiatives were direct to patient service delivery while a number of other FFtF aspects increased knowledge and support of primary care interventions through workforce development. This included Nurse Alcohol and Other Drug Credentialing and a GP phone line (for GPs to seek immediate professional guidance in support of their patients). An independent evaluation was also funded which reported back to the Ministry of Health in September 2018. *The total cost of all aspects of FFtF was \$1,676,000.00.* Please note that FFtF continued up until September 2018 (Q1 2018/19)

12. What services, functions or outputs have been cut, reduced, or had funding reprioritised from in the last financial year? Describe the service or function concerned and estimate the cost saving.

Response to Question 12

Rheumatic Fever

Rheumatic Fever Prevention funding has been reprioritised from a 2017/2018 underspend associated with under delivery in the contracts with primary care across Waitemata DHB and Auckland DHB. To target those at highest risk a model is currently being scoped for the use of this funding based on the research findings from the Rheumatic Fever Case Control Study..

Breastfeeding peer support pilot with Plunket

A pilot programme was undertaken with Plunket to provide community based breastfeeding support via a peer to peer counsellor model. A priority for the programme was to reach communities where breastfeeding rates are persistently lower, in particular among Māori and Pacific communities. The programme while effective at supporting breastfeeding for the women involved, the reach among Māori and Pacific women and communities was insufficient and was discontinued.

Spending by the Auckland DHB from 1 July to 31 December 2017 was \$18,937.50. As noted to the Health Select Committee last year, the programme was ended in December 2017.

Fairleigh Lodge

The Director of Fairleigh Lodge sent a formal letter of exit for this 25 bed facility, funded as a level 3 residential rehabilitation service, on 5 April 2018. Financial sustainability was given as a significant factor in the decision to close the service. Level 3 services are contracted to provide a lower level of

support than level 4 beds, and provide active awake support between 7am to 11pm and not awake support 24/7. Several of the Auckland DHB contracted level 3 services (including Fairleigh Lodge) cater to an aging population, with a range of co-morbidities (cognitive impairment, intellectual disability etc.) and personal care needs as well as mental health needs, and these services are delivering over and above the contracted level 3 provision. Planning for an alternative service to Fairleigh Lodge was informed by the level of need identified through completion of Support Needs Assessments (SNAP) and Health of Older People Needs Assessment Service Coordination (NASC) and identified that the majority of residents required a higher than a level 3 service. Given the three months' notice of exit, it was not possible to plan for a new service, run a Request for Proposals (RFP) process within this timeframe, and have a replacement service functioning by 1 July 2018. Alternative options were developed for this group. They involved contracting four new beds with Hinemoa at level 4 (\$340,472 per annum), contracting one new bed with Emerge Aotearoa at Level 4 (\$85,118 per annum), contract one new bed with Delamore at Level 3 (\$55,323.05 per annum), and establish up to four named NHI contracts for placement in Rest Home services for clients not eligible for HOP subsidies to meet the identified needs.

13. What programmes or projects, if any, were delayed in the 2017/18 financial year and what was the reason for any delay in delivery or implementation?

Response to Question 13

The following facilities projects were delayed against the original business case timeframes for various reasons, including the timeframe to obtain consents, procure resources and fitting in with Clinical workload and staff availability:	
Project Name	Reason for delay/completion date
ACH Level 2 Emergency Dept. extension	Project complete, undergoing defects review before final payment released
Security for Safety	Multi-year project to be completed 2018/19
ACH Site - New substation for Vector incomers	Project scheduled for completion Q4 2018/19
<p>It is noted that Auckland DHB's IT projects are mostly managed by our IT Shared Service (healthAlliance), a small number are managed directly by Auckland DHB. The attachment shows that in 2017/18 10 IT projects managed by Auckland DHB were delayed and 14 healthAlliance managed projects were delayed.</p> <p>The following IT projects were delayed.</p>	
Project Name	Reason for delay
Business Objects 4.2 Upgrade	Staged rollout of the system took longer than anticipated due to technical issues, project completion Mar-19.
3M Clinical Record System Upgrade	The time and work involved to configure and install the non-production environments

	being longer than anticipated. Due to go live Mar-19.											
CSSD Single Instrument Tracking - TDOC upgrade	The system was rolled out Jul-18 with final costs in Q3 2018/19											
<p>Stage one of the Linear accelerator project encountered IS/IT technical issues which pushed the timelines for stage 2 out to Oct-18, project to be complete Dec-19</p> <p>The following are performance improvement projects that were delayed against the original business plan timeframes for various reasons:</p> <table> <thead> <tr> <th>Outpatient Projects</th> <th>Reason for Delay</th> </tr> </thead> <tbody> <tr> <td>Urology surveillance/database</td> <td> <ul style="list-style-type: none"> • Phasing of project management resource </td> </tr> <tr> <td>Obstetrics/ Gynaecology eConsults</td> <td> <ul style="list-style-type: none"> • Service-requested pause during transition to new directorate senior leadership </td> </tr> <tr> <td>Vascular Model of Care</td> <td> <ul style="list-style-type: none"> • Overlap with other technology/ regional initiatives – project on hold to avoid duplication </td> </tr> <tr> <td>Lung Cancer FUs</td> <td> <ul style="list-style-type: none"> • Clinician-requested pause to accommodate ethics approvals/ experiment design as part of PhD programme • To recommence support once PhD requirements achieved </td> </tr> <tr> <td>Preadmission One Stop Shop</td> <td> <ul style="list-style-type: none"> • Successful pilot delivered in 3 services • Roll-out to BAU paused while service prepares business case for additional resource </td> </tr> </tbody> </table> <p><u>Releasing Time to Care - Community</u> Delayed due to changes in the directorate, including physically changing localities as well as key personnel.</p> <p><u>Advance Care Planning</u> ACP was handed to HQSC (nationally) and back to the business (locally) at the end of the 16/17 financial year.</p> <p><u>Post Natal Pathway</u> Delayed due to a number of vacancies in the directorate and other priorities for the service. We anticipate this may commence in early 2019 depending on service readiness.</p>	Outpatient Projects	Reason for Delay	Urology surveillance/database	<ul style="list-style-type: none"> • Phasing of project management resource 	Obstetrics/ Gynaecology eConsults	<ul style="list-style-type: none"> • Service-requested pause during transition to new directorate senior leadership 	Vascular Model of Care	<ul style="list-style-type: none"> • Overlap with other technology/ regional initiatives – project on hold to avoid duplication 	Lung Cancer FUs	<ul style="list-style-type: none"> • Clinician-requested pause to accommodate ethics approvals/ experiment design as part of PhD programme • To recommence support once PhD requirements achieved 	Preadmission One Stop Shop	<ul style="list-style-type: none"> • Successful pilot delivered in 3 services • Roll-out to BAU paused while service prepares business case for additional resource
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Preadmission One Stop Shop	<ul style="list-style-type: none"> • Successful pilot delivered in 3 services • Roll-out to BAU paused while service prepares business case for additional resource 											

14. How much funding for specific projects, policies or programmes has been carried forward from the 2017/18 financial year to the current financial year? For each, please provide the following details:

- Name of project, policy or programme
- Amount of funding brought forward
- Amount of funding already spent
- Amount of funding originally budgeted for the project
- Estimation completion date.

Response to Question 14

The Table below provides the details on all capital projects >\$1M that experienced delays during 2017/18 and have been carried forward to the current financial year.

Facilities and IT/IS Projects:

Name of project, policy or programme	Amount of funding brought forward	Amount of funding already spent	Amount of funding originally budgeted for the project	Estimation completion date.
Linear Accelerator	\$3,614	\$4,729	\$8,343	Dec-18
ACH Level 2 Emergency Dept. extension	\$799	\$7,651	\$8,450	Sep-18
Security for Safety	\$4,067	\$2,063	\$6,130	Mar-19
ACH Site - New substation for Vector incomers	\$991	\$4,949	\$5,940	Dec-18
Business Objects 4.2 Upgrade	\$192	\$1,654	\$1,846	Dec-18
3M Clinical Record System Upgr	\$1,172	\$113	\$1,285	Mar-18
CSSD Single Instrument Tracking - TDOC upgrade	\$566	\$752	\$1,318	Dec-18

15. How many projects or contracts that were due to be completed in 2017/18 were shelved, curtailed or pushed into out years? For each, what was the project name, what was the total budgeted cost, what is the actual cost to date, what was its purpose and why it was not completed in 2017/18?

Response to Question 15

IT Projects

Auckland DHB's IT projects are mostly managed by our IT Shared Service (healthAlliance), a small number are managed directly by Auckland DHB. These projects are detailed below:

Projects Pushed to Out Years: 14 ADHB Managed Projects, 7 healthAlliance Managed Projects

Projects Shelved or Curtailed: 4 ADHB Managed Projects, 19 healthAlliance Managed Projects

Details are contained in [Question 15 – Appendix 1](#)

Facilities Projects:

Project Name	Budget	Cost to Date	Reason for non-completion

G04 Level 2 Eye Ward corridor floor repairs	\$ 18,000.00	\$ -	Project put on hold due to re-prioritisation of capital projects.
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16. What user charges were collected in the last financial year and what was the revenue from each of them? How does this compare to the previous financial year?

Response to Question 16

The following user charges have been collected in the last five financial years:

Type (In \$s)	2017/18	2016/17	2015/16	2014/15	2013/14
Fertility Plus Private Patients Income	1,223,064	1,118,040	1,198,892	1,099,828	1,169,773
Non-residents income	18,461,503	18,701,985	17,435,974	16,178,946	15,665,012
Patient Co-Payments - Dental	314,380	329,447	333,765	385,448	405,201
Other Patient-related Income	11,598	22,043	9,100	11,078	12,798
Car Parking Fees	5,576,295	5,110,890	4,427,198	4277380	4495151
Total	25,586,840	25,282,405	23,404,929	21,952,680	21,747,935

17. How much funding was allocated to capital works in the last financial year? How does this figure compare to that allocated and that spent in the previous four financial years?

Response to Question 17

	2017-18	2016-17	2015-16	2014-15	2013-14
Budget	104,135	90,353	94,991	92,219	55,325
Actual	48,845	34,825	64,386	63,527	35,972
Deferred Spend	55,290	55,528	30,605	28,692	19,353

18. What land, building, and other assets were sold in 2017/18? What processes were undertaken for the disposal of these assets and how much did they sell for? How does that compare to each of the previous four financial years?

Response to Question 18

The Auckland DHB has an asset disposal process and, generally assets, with the exception of motor vehicles, are not sold. Wherever possible they are reused within the DHB. End of life assets are sometimes able to be used as a trade in for new products or donated to the Medical Aid Abroad Society.

The table below shows the proceeds of sales for motor vehicles.

Year	Proceeds of Sales
2013/14	\$188,000
2014/15	\$161,000

2015/16	\$169,000
2016/17	\$470,000
2017/18	\$375,000

19. How much floor space does your department, agency or organisation lease and what is the annual cost per square metre and total cost in each building of those leases? How does this compare with each of the previous four financial years?

Response to Question 19

Service	Lease Address	Tenant	Floor Space Per SQM	Rent Per SQM	Annual Rent (\$) 30/06/18	Annual Rent (\$) 30/06/17	Annual Rent (\$) 30/06/16	Annual Rent (\$) 30/06/15	Annual Rent (\$) 30/06/14
Dental	CMDHB- Buckland Road 235, Mangere	ADHB	80	\$382	\$31,596	\$31,596	\$ 31,596	\$31,596	\$30,240
Dental	CMDHB Middlemore Dental	ADHB	472	\$300	\$141,690	\$141,690	\$126,108	\$126,108	\$126,108
Mental H	Great South Road 218, Remuera	ADHB	250	\$267	\$75,000	\$75,000	\$66,000	\$62,000	\$62,000
Mental H	Kyber Pass Level 3, 126 (Segar House)	ADHB	470	\$275	\$148,935	\$148,935	\$147,900	\$147,900	\$147,900
Mental H	New North Road 615, Mt Albert-St Lukes Community Health Centre	ADHB	1153	\$160	\$221,000	\$195,658	\$195,658	\$187,655	\$187,655
Mental H	61 Ostend Road, Waiheke Island	ADHB	125	\$332	\$45,600	\$45,600	\$42,000	\$ 42,000	\$42,000
Mental H	Pleasant View Road 15, Panmure (Manaaki House)	ADHB	872	\$199	\$197,800	\$174,418	\$174,418	\$174,418	\$123,620

Mental H	Ponsonby Road 308 (Taylor Centre)	ADHB	1043	\$214	\$ 267,153	\$267,153	\$264,940	\$264,940	\$258,753
Mental H	Granville Tce 24,26,27 Parnell (Thrive)	ADHB	768	\$172	\$132,033	\$173,298	N/A	N/A	N/A
Starship	Grafton Road 99, Grafton (Multi Agency Centre)	ADHB	555	\$208	\$122,550	\$122,550	\$108,951	\$108,951	\$101,036
Starship	Ecom Building - 3 Ferncroft St	ADHB	444	\$218	\$ 96,793	\$ 96,793	\$88,529	\$87,120	\$87,120
Sexual	Cape Road 21 (12 Waddon Place, Mangere)	ADHB	252	\$255	\$67,783	\$66,345	\$66,345	\$63,054	\$ 62,954
Sexual	Glenfield Road 418 (Peach House)	ADHB	230	\$230	\$60,733	\$ 60,733	\$57,920	\$ 57,920	\$57,920
Sexual	Great North Road 362, Henderson	ADHB	221	\$167	\$37,000	\$ 37,000	\$33,500	\$33,500	\$31,400
Lab Plus	Auckland Pathology Services 47 Carbine Road	ADHB	574	\$300	\$186,939	\$182,380	\$177,929	\$173,590	N/A
Lab Plus	Auckland Pathology Services 46 Taharoto Road	ADHB	160	\$261	\$49,500	\$49,500	\$46,224	\$46,224	N/A

Lab Plus	Montreal St 296, CHCH	ADHB	65	\$264	\$21,605	\$21,605	\$21,605	N/A	N/A
Community Centre	Clifton Ctr 8, Panmure	ADHB	80	\$206	\$18,072	\$18,072	\$18,000	N/A	N/A
Community Health	Apirana Ave 272 Glen Innes	ADHB	140	\$151	\$21,130	\$21,130	\$20,124	N/A	N/A
Mental H	GT South Road 95, Greenlane	ADHB	363	\$220	\$95,300	N/A	N/A	N/A	N/A
Sexual	Totara Ave , 32 , Level 2 , New Lynn	ADHB	160	\$242	\$38,700	N/A	N/A	N/A	N/A

20. Were any of your offices relocated in 2017/18? In each case please provide where did the office move from and to, a breakdown of the cost of relocating, the amount of any saving or increase in rent paid resulting from the move, the floor space of the original and new office, and the reason for the relocation. Please also provide these details for each of the previous four financial years.

Response to Question 20

Service Relocation in 2017/18	Relocate From	Relocate To	Cost of Relocating	Increase in rent	Original Floor Area (Sqm)	New Floor area (Sqm)	Reason for relocating
Mental H	Great South Road 218, Remuera	GT South Road 95, Greenlane	\$135,000	\$20,300	250	363	The service operated from a very outdated house which was no longer fit for purpose and the service needed to consolidate five teams located within various DHB sites onto a single site to provide an integrated Early Intervention service for people experiencing first episode Psychosis.
Sexual	Great North Road 362, Henderson	Totara Ave, 32 , Level 2 , New Lynn	\$22,000	\$1,700	221	160	Old building was no longer suitable for health services with maintenance issues, including no functional lifts. A more suitable building with modern clinic rooms and

							facilities was found within the New Lynn Health Facility and the new transport hub thus enabling the DHB to share resources and provide better services to the public
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Previous 4 Years Relocation

There was no external office relocation in the previous 4 years

21. How much was spent on each renovation, refurbishment or redecoration project in offices or buildings of the department, agency or organisation that cost more than \$5,000 in the 2017/18 financial year? For each, please provide the following details:

- a. A description of the renovation carried out
- b. Location of the project
- c. Name of provider(s) or manufacturer(s)
- d. Type of product or service generally provided by the above
- e. Cost of the project
- f. Completion date
- g. Whether tenders were invited, if so, how many were received
- h. List separately any single item of furniture or fixture worth more than \$2,500 with its cost.

Response to Question 21

A summary of renovation, refurbishment and redecoration projects is provided below:

Details of Project	Location of Project	Name of provider/ manufacturer	Type of Service	Cost of Project	Completion Date	Tender
P6739 Oncology Disabled Toilet	A08 - Oncology	CPL Ltd	Refurbishment	\$45,037	31/03/18	Yes 3
P7128 Ward 34 Bathroom Refurb	A32 - Auckland City Hospital - Main Building	ADM Carpentry	Refurbishment	\$53,327	30/10/17	Panel
P7136 CED Bathroom repairs	A32 - Auckland City Hospital - Main Building	ADM Carpentry	Refurbishment	\$32,682	31/03/18	Panel

P7164 Starship Ward 23B paint	A02 - Starship	ADM Carpentry, JR Webb	Refurbishment	\$42,203	28/02/18	Panel
P7165 En- suite Refurbishmen t	A32 - Auckland City Hospital - Main Building	ADM Carpentry	Refurbishment	\$82,852	31/03/18	Panel
P7153 G04 GF Public Toilet Ref	G04 - Greenlane Clinical Centre	CPL Ltd	Refurbishment	\$80,936	30/06/18	Panel
P7236 Ward 23B Bathroom Refurb	A32 - Auckland City Hospital - Main Building	ADM Carpentry	Refurbishment	\$46,127	30/04/18	Panel
P7231 Ward 23B Bathroom Refurb	A32 - Auckland City Hospital - Main Building	ADM Carpentry, CPL Ltd	Refurbishment	\$41,105	30/06/18	Panel
P7229 APU Male Staff Change Rm	A32 - Auckland City Hospital - Main Building	ADM Carpentry	Refurbishment	\$88,466	30/06/18	Panel
P7263 A35 Carpet Replacement	A35 - Te Whetu Tawera- Acute Mental Health Unit	Crown Flooring	Refurbishment	\$17,138	31/05/18	Panel
P6866 AED Floor Vinyl Install	A32 - Auckland City Hospital - Main Building	Crown Flooring, ADM Carpentry	Refurbishment	\$27,629	31/12/17	Panel

P7061 Ward 65 Bathroom Repairs	A32 - Auckland City Hospital - Main Building	ADM Carpentry	Refurbishment	\$29,474	1/01/18	Panel
P6598 A01 L5 Refurbishmen t P2	A01 - Support Building	Crown Flooring, Practec etc.	Redecoration	\$432,413	30/06/18	Yes 3
P6928 L3 CCU Ward 34 Flooring	A32 - Auckland City Hospital - Main Building	Crown Flooring, ADM Carpentry etc.	Refurbishment	\$174,375		

22. What offices were closed in 2017/18 and how much is the closure of each office expected to cost or save? What offices were closed in each of the previous four financial years?

Response to Question 22

No offices were closed for the year 2017/2018

23. What offices did your department, agency or organisation open in 2017/18 and how much is the opening of each office expected to cost or save? What offices were opened in each of the previous four financial years?

Response to Question 23

There were no new offices opened in the 2017/2018 year

Previous years (prior to 2017/2018) offices are listed below

Service	Lease Address	Service/Purpo se	Annual Rent 30/06/1 8	Annual Rent 30/06/1 7	Annual Rent 30/06/1 6	Annual Rent 30/06/1 5	Annual Rent 30/06/1 4
Mental H	Granville Tce 24,26,27 (Parnell Thrive)	The contract for provision of Eating Disorder services was transferred to ADHB from Emerge Aotearoa	\$132,03 3	\$173,29 8	N/A	N/A	N/A
Lab Plus	Auckland Pathology Ser vices 47 Carbine Road	Provision for an Anatomical Pa th Lab	\$186,93 9	\$182,38 0	\$177,92 9	\$173,59 0	N/A

Lab Plus	Montreal St 296 , CHCH	ADHB holds the contract for provision of a National Forensic Pathology Service on behalf of the Ministry of Justice which funded the lease from an existing contract	\$21,605	\$21,605	\$21,605	N/A	N/A
Lab Plus	Auckland Pathology Services 46 Taharoto Road	Pathology Service Transferred from Diagnostic Medlab Services	\$49,500	\$49,500	\$46,224	\$46,224	N/A
Community Centre	Clifton Ctr 8,Panmure	Space to accommodate the Tamaki mental health and wellbeing programme. The aim is to create an experience of health and wellbeing focused on the wellness of the whānau & community.	\$18,072	\$18,072	\$18,000	N/A	N/A
Community Health	Apirana Ave 272 Glen Innes	A base for the Community Nursing team to service increased access to East Auckland patients.	21,130	\$21,130	\$20,124	N/A	N/A

24. How many regional offices, other than your department, agency or organisation's head office, reduced their opening hours during the 2017/18 financial year listed by new and former opening hours, date of change, and location?

Response to Question 24

There are no known changes in opening hours.

25. How many vehicles did your department, agency or organisation own during the 2017/18 financial year and to what office are each of these vehicles assigned by vehicle year and vehicle model? How many were owned during each of the previous four financial years and to what office are each of these vehicles assigned by vehicle year and vehicle model?

Response to Question 25

Auckland DHB owned 348 vehicles in 2017/2018

Previous Financial years

- 2016/17 = 336
- 2015/16 = 342
- 2014/15 = 342
- 2013/14 = 345

A detailed listing is contained in Question 25 – Appendix 1.

26. What was the total amount spent on purchasing vehicles during the 2017/18 Financial year and to what office were each of these vehicles assigned by vehicle year and vehicle model? How much was spent during each of the previous four financial years and to what office are each of these vehicles assigned by vehicle year and vehicle model?

Response to Question 26

2017/18 Spend = \$206,908.71

2016/17 Spend = \$31,041.09

2015/16 Spend = \$557,594.37

2014/15 Spend = \$711,215.39

2013/14 Spend = \$693,162.39

A detailed listing is contained [Question 26 – Appendix 1](#)

27. Were any labour and/or contractor costs been capitalised into capital project costs during the 2017/18 financial year, if so, for each project what is the breakdown by project of labour vs. non labour costs?

Response to Question 27

The following labour and non-labour costs were capitalised into capital projects during FY2017/18 financial year.

Project	Labour	Non-Labour	Total	
Project 6787 Extn Redesign Endoscopy	\$99,500.00	\$2,660,168.79	\$2,759,668.79	AK-16-C-4103006B01

Project 6824 Planview PM software	\$11,250.00	\$43,727.28	\$54,977.28	AK-16-C-4506429A16
Project 6344 Upgrade SS Patient Lifts	\$28,062.50	\$1,189,926.19	\$1,217,988.69	AK-16-C-4506429B04
ACH B32 theatre lift doors upg	\$15,675.00	\$275,301.55	\$290,976.55	AK-16-C-4506429B09
Project 6902 ACH Copper Silver Capaci	\$7,500.00	\$330,518.50	\$338,018.50	AK-16-C-4506429B32
Project 6507 AED Acute Flow L2 Expansion	\$232,690.50	\$7,554,004.17	\$7,786,694.67	AK-17-C-4102007B01
Project 6854 SF1079 Starship L5 Refurb	\$238,737.78	\$9,538,869.03	\$9,777,606.81	AK-17-C-4203116B01
Project 6754 SF1258 SSH L3 Outpatients Reno	\$63,929.50	\$1,623,469.98	\$1,687,399.48	AK-17-C-4303633A01
Project 6882 Linear Accelerator replacement	\$127,265.00	\$7,872,901.63	\$8,000,166.63	AK-17-C-4353628B01
Project 7003 Carpark B Cycle & SS ED	\$3,000.00	\$35,630.09	\$38,630.09	AK-17-C-4506429A14
Project 6503 Blood Bank Extension	\$118,822.50	\$1,402,409.13	\$1,521,231.63	AK-17-C-4506429B02
Project 6817 P6829 Pedestrian Safety	\$23,975.00	\$331,071.37	\$355,046.37	AK-17-C-4506429B06
Project 7906 Copper Silver Ionisation	\$4,500.00	\$157,079.96	\$161,579.96	AK-17-C-4506429B17
Project 7905 Copper Silver Ionisation	\$4,500.00	\$152,892.84	\$157,392.84	AK-17-C-4506429B19
Project 7904 Copper Silver Ionisation	\$4,500.00	\$151,766.49	\$156,266.49	AK-17-C-4506429B20

28. Does your department, agency or organisation have a policy about the use of personal email accounts (e.g. Gmail accounts) in the workplace; if so, what policies are in place and do those policies include a prohibition on the use of such accounts for official government business? How many breaches of any such policy during the last financial year were reported and how does this compare to each of the previous four financial years?

Response to Question 28

The email and Internet usage policy covers the use of personal email account. A restriction is also in place that blocks staff from accessing personal email accounts (e.g. Gmail accounts). During the previous financial year no breaches were reported. The Email and Internet Usage policy was implemented in September 2017 so no previous year's data is available to compare.

Question 28 – Appendix 1 Email and Internet Usage Policy

29. What IT projects, if any, were shelved or curtailed in the 2017/18 year and how much will have been spent on each project before it is shelved or curtailed?

Response to Question 29

Auckland DHB's IT projects are mostly managed by our IT Shared Service (healthAlliance), a small number are managed directly by Auckland DHB. These projects are detailed below:

Projects Shelved or Curtailed in 2017/18: 5 ADHB Managed Projects, 13 healthAlliance Managed Projects

What IT projects, if any, were shelved or curtailed in the 2016/17 year and how much will have been spent on each project before it is shelved or curtailed?

Project Name	Amount Spent	Reason
Due to be completed in 2017/18 but shelved or curtailed		
ADHB Managed Projects		
Patient Portal Integration Strategy	-	Decision not to proceed
Implementation of Pager Replacement Solution	-	Did not proceed as solution selected was technically unsuitable
Contract Management System	-	Decision not to proceed
Kiosk Web Interface Development (payroll)	-	Decision not to proceed
ePrescribing & Administration (ePA) - Phase 3	-	Cancelled due to lack of funding
healthAlliance Managed Projects		
19313 - Physical Server Replacements OOS BER (5134)	-	Cancelled and included in scope of overall resilience programme
19312 - Regional Tier 2 Storage Growth (5109)	-	Cancelled and included in scope of overall resilience programme
Regional Wifi Services (5084)	-	Cancelled and included in scope of overall resilience programme
Regional AD Functional Upgrade (5077)	-	Cancelled and included in scope of overall resilience programme
ADHB Aria Scheduling Medical Oncology and Haematology (5118)	-	Cancelled as no longer required
Regional SharePoint Review (5206)	23,195	Cancelled and included in scope of overall resilience programme
Regional Citrix User Growth (5108)	-	Cancelled and included in scope of overall resilience programme
19234 - W10 -Citrix Build, incl lic & svers (5137)	-	Cancelled and included in scope of overall W10 programme
19234 - W10 -Mobile build, incl lic & svrs (5138)	-	Cancelled and included in scope of overall W10 programme
19254 - Citrix - Licences and Infrastructure (5139)	-	Cancelled and included in scope of overall resilience programme
Regional Innovation - Windows Server 2016 (5363)	-	Cancelled and included in scope of overall resilience programme
ADHB NCAMP 18 - CMS 41 (5157)	-	Cancelled and incorporated into CMS40 project
Regional Consolidation of DHB / Departments to healthcare domain (3335)	-	Cancelled and included in scope of overall W10 programme

30. What IT projects, if any, were completed or under way in the 2017/18 year? For each, please provide the following details:

- Name of project
- Initial estimated budget
- Initial estimated time frame
- Start date
- Completion date or estimated completion date.
- Total cost at completion or estimated total cost at completion.

Response to Question 30

ADHB's IT projects are mostly managed by our IT Shared Service (healthAlliance), a small number are managed directly by ADHB. Please note that neither healthAlliance nor ADHB record the initial estimated timeframe.

ADHB - 85 Projects

healthAlliance - 77 Projects for ADHB only, 6 Projects for ADHB and 1 or more regional DHB, 146 Northern Region projects (ADHB funds a share)

Details are listed in [Question 30 – Appendix 1](#)

31. How much was spent for software licensing fees in the 2017/18 financial year and how does this compare with spending in each of the previous four financial years?

Response to Question 31

Auckland DHB FY2017/18 spend on software licensing was \$2.408m. Health Alliance, as the regional provider, spent \$29.845m. This spend is not split by Northern Region DHBs.

FY2017/18 spend is slightly higher than the average over the previous four financial years.

	FY17/18	FY16/17	FY15/16	FY14/15	FY13/14
Auckland DHB	\$2,408	\$1,987	\$1,258	\$2,114	\$1,040
Health Alliance	\$29,845	\$25,145	\$23,909	\$21,309	\$22,494

32. How many websites did your department, agency or organisation run in 2017/18 and for each, what is it called, what is its URL, when was it established, what is its purpose and what is the annual cost of operating it?

Response to Question 32

A list of websites run by Auckland DHB and its associated agencies in 2017/18 is included below. The primary purpose of the websites is to provide information online, including contact details for our services. Many of our websites have resources for health professionals, and are used to engage with patients, and seek feedback on patient experiences.

Detailed cost information for these websites is not readily available as these costs are embedded in various operating budgets of departments within Auckland DHB and its associated agencies and support is provided by a multitude of internal and external parties. Collection of this additional information across the DHB and its associated agencies was not feasible within the provided timeframes and would incur substantial cost.

Costs per site often include initial development costs which vary widely, hosting fees of approximately \$450-1000 per annum, domain registration costs of approximately \$46-65 per annum (depending on how long it has existed) per domain name and use of a server (physical or virtual). Staff support costs include hardware and web service/software support costs which vary widely; estimated annual depreciation cost per website is approximately \$1000 per site.

Website and Portal Name	Portal Description	Date Created
URL: www.adhb.health.nz	Auckland DHB provides information for patients on how to access health care, particularly the health and support services we provide at Auckland City Hospital, Greenlane Clinical Centre, Starship Children's Hospital, Rehab Plus, the Buchanan Centre and within the community and at home. The website provides ways for patients to engage with us and provide feedback. It includes resources for health professionals, and is where we publish Annual Plans and Annual Reports, Quality Accounts, Board papers, Media Releases and other documents of public interest.	2015
Name: Auckland District Health Board <i>Note: Replaces www.adhb.govt.nz which was the Auckland DHB website from 2000-2015</i>		
URL: www.arphs.govt.nz Name: Auckland Regional Public Health Service (ARPHS) <i>Note: This website has since been re-launched in November 2018 as www.arphs.health.nz</i>	Provides information on ARPHS - Auckland's regulatory public health agency serving Auckland's diverse populations through health protection, prevention and promotion. ARPHS is hosted by the Auckland DHB and funded predominantly by the Ministry of Health (MOH).	2003
URL: www.aucklanddoctors.co.nz Name: Northern Regional Training Hub Ltd	The Northern Regional Training Hub Ltd (NoRTH) is responsible for the coordination of recruitment, postgraduate training and education throughout the northern North Island region, which includes North Auckland & urban Auckland City.	2008
URL: www.labplus.co.nz Name: LabPLUS	LabPLUS is the tertiary referral medical laboratory of Auckland City Hospital, New Zealand. LabPLUS is an IANZ accredited medical laboratory and is one of New Zealand's premier laboratories. We offer a comprehensive pathology service for Auckland City Hospital, National Women's Hospital, Starship Children's Hospital, and the Greenlane Clinical Centre. LabPLUS is also a major referral laboratory for specialised laboratory tests for New Zealand and the Pacific Islands.	2000

URL: www.careermed.co.nz	This website offers you a structured way of thinking about your options and your choice of specialty. You will gain some insights into who you are as a person and what you are looking for in a job or specialty.	2008
Name: CareerMed <i>Note: this website will be shut down at the end of 2018, and the content migrated to http://www.adhb.health.nz/health-professionals/careermed/</i>		
URL: www.refugeehealth.govt.nz	The ARPHS is a mainstream provider of public health services in the Auckland region. ARPHS itself is sited within the Auckland District Health Board organisation. ARPHS provides a range of Refugee Health Services to the Auckland region.	2002
Name: Refugee Health <i>Note: this website content has now been hosted through the main website http://www.arphs.health.nz/health-professionals/refugee-health/</i>		
URL: www.cvicu.co.nz/	Provides information on the Cardiothoracic and Vascular Intensive Care Unit (CVICU) at Auckland City Hospital.	2017
Name: Cardiothoracic and Vascular Intensive Care Unit (CVICU)		
URL: www.healthyaucklandtogether.org.nz	The ARPHS manages the website for Healthy Auckland Together, a coalition of 26 organisations representing local government, mana whenua, health agencies, NGOs, university and consumer interest groups."	2015
Name: Healthy Auckland Together		
URL: www.nationalwomenshealth.adhb.govt.nz	Provides information on services at National Women's Health in Auckland City Hospital for women who need maternity, new-born, gynaecology and fertility care.	1997
Name: National Women's Health		
URL: www.rangatahiprogramme.co.nz	The Rangatahi programme supports Māori and Pacific Year 12 and Year 13 students within the Auckland and Waitemata District Health Board boundaries to pursue a career in health.	2013
Name: Rangatahi Programme		
URL: www.healthvoice.org.nz	Reo Ora - Health Voice invites members of the community to participate in online forums and surveys. It is one of the ways Auckland DHB seeks feedback from our community on current services and how we can improve health outcomes.	2011
Name: Reo Ora Health Voice		
URL: www.trauma.co.nz	Provides clinician-focused information on the Trauma Service at Auckland City Hospital, including clinical guidelines.	2017
Name: Trauma		
URL: www.thehub.arphs.govt.nz	The Hub is an internal website that provides information to facilitate the work of ARPHS' staff. It contains organisational and development information, including	2007
Name: The Hub		

	policy and procedure documents.
URL: www.adhb.hanz.health.nz	Hippo is Auckland DHB's internal 'intranet' site for all employees. It contains news and information, policies, procedures and other resources staff need to carry out their work
Name: Hippo	2016
URL: www.tamakiwellbeing.org.nz	To provide information on the Tāmaki Mental Health and Wellbeing initiative which was launched in 2013 to help create a new experience of mental health and wellbeing support in Tāmaki.
Name: Tāmaki Mental Health and Wellbeing	2015

33. How many data security issues were identified in 2017/18 and how many data security issues were there in each of the previous four financial years? If there were breaches, what were they and what are the titles of any reports into them?

Response to Question 33

There were no data security issues reported to, or investigated by, healthAlliance during 2017/18, nor in the preceding financial years.

34. How many laptop computers, tablet computers and hard drives, if any, provided or paid for by your department, agency or organisation have been lost or gone missing in the 2017/18 financial year; and how many of these were returned to or found by the agency or organisation if any? How many were lost or missing and how many subsequently returned or found in each of the previous four financial years?

Response to Question 34

There were two laptop computers, tablet computers or hard drives reported as lost or missing in FY 2017/18. One was found and returned.

The number reported as lost or missing in the previous four financial years were:

FY 2016/17: 0

FY 2015/16: 3 (none were returned / found)

FY 2014/15: 0

FY 2013/14: 0 *

**Figures for the first half of FY 2013/2014 are not available due to the introduction of a new help desk computer system in February 2014.*

35. Please provide a list of all reports that were prepared in 2017/18 relating to:

- baseline update (if applicable)
- value for money
- savings identified

Response to Question 35

The following reports are prepared in relation to value for money and other savings for 2017/18:

- Finance Risk and Assurance Committee progress reports against Savings Initiatives
- Hospital Advisory Committee reports

36. Please provide copies of the current work plan.

Response to Question 36

Details of the DHB work programme can be found in the Auckland DHB available on the [2017/18 Annual Plan](#) Auckland DHB website.

37. Please list projects and major policy initiatives progressed in 2017/18.

Response to Question 37

Details of the major initiatives progressed in 2016/17 can be found in our Annual Report and Quality Account, available on our website: <http://adhb.health.nz/about-us/planning-and-funding-2/planning-documents/>

38. Please provide copies of any reports made to the Minister in 2017/18 about performance against the agency or organisation's Statement of Intent, Statement of Corporate Intent, Statement of Performance Expectations or Output Plan.

Response to Question 38

The key output agreement between the Minister and the DHB is the Statement of Service Performance. The Auckland DHB Annual Report shows progress against the DHB Accountability and Output measures:

https://www.parliament.nz/resource/en/NZ/PAP_82537/4c8b67f434d309ddf95d5e5469ce196cc02b0fb4

The Ministry of Health quarterly reporting includes health targets and indicators of DHB performance – both numerical and narrative. Many of these are included in the Statement of Intent/Statement of Performance Expectations, and allow the Ministry to monitor progress throughout the year.

39. How many evaluations of policies or programmes were completed in 2017/18? Please provide details of who carried out the evaluation, the cost of the evaluation, the date completed, and its main findings.

Response to Question 39

Pregnancy and Parenting Programmes

An Evaluation of the Pregnancy and Parenting Programmes for Waitemata DHB and Auckland DHB was commissioned via RFP process. The successful evaluation tendering organisation, Synergia Ltd completed an evaluation of the Pregnancy and Parenting evaluation programmes procured by Waitemata DHB and Auckland DHB. This evaluation included the programmes delivered by the DHB provider arms in Women's Health, other providers contracted to deliver pregnancy and parenting

education and the utilisation of the Mokopuna Ora website and app tools for delivering the Mokopuna Ora Pregnancy and Parenting curriculum. Final report submitted February 2018. The cost for Auckland DHB was \$39,175.

The main findings and link to final report are in the next question.

40. What reviews of capability were started or completed in 2017/18? What aspects of capability were or are being reviewed? Who undertook or is undertaking these reviews and when were or will they be completed?

Response to Question 40

No capability reviews have been completed by HR in the FY2017/2018.

41. Please provide details of all monitoring, evaluation and auditing of programmes or initiatives undertaken or commissioned by your department, agency or organisation in the 2017/18 financial year (including details of all performance measures, targets and benchmarks and whether programmes contributed to desired outcomes in an efficient and effective manner).

Response to Question 41

Pregnancy and Parenting Programmes

As outlined in Question 39 an Evaluation of the Pregnancy and Parenting Programmes for Auckland DHB and Waitemata DHB were commissioned. The main findings and final report are detailed in [Question 41 – Appendix 1](#) and [Question 41 – Appendix 2](#)

42. What policies were in place in 2017/18 on accepting corporate gifts or hospitality? How did this compare to the previous financial year? Please list all corporate gifts or hospitality accepted by staff in the 2017/18 financial year with the following details:

- Gift or hospitality accepted
- Position of staff member who accepted
- Estimated value
- Date received
- Name of the organisation or individual who paid for/gave the gift or hospitality.

Response to Question 42

In 2016/17 Auckland DHB had the following policies regarding accepting corporate gifts or hospitality:

- Sponsorship, Donations and Corporate Hospitality Policy
- Sponsor and Donor Interaction with Auckland DHB Policy
- Standards of Conduct Policy
- Conflict of Interest Policy
- Expenses – Work Related Policy
- Human Resources Principles – Rewards and Recognitions

[Question 42 – Appendix 1 - Auckland DHB Register/declaration of Gifts to Staff For 1 July 2017 - 31 June 2018](#)

In 2017/2018 the Standards of Conduct Policy was withdrawn on 10 September 2018.

43. What policies were in place in 2017/18 on the organisation giving gifts to external organisations or individuals? How did this compare to the previous financial year? Please list all gifts given to external organisations or individuals in the 2017/18 financial year. For each, please provide the following details:

- Gift given
- Name of external organisation or individual
- Reason given
- Estimated value
- Date given.

Response to Question 43

Auckland DHB has a Sponsorship, Donations, Gifts and Hospitality policy.

As a general rule, Auckland DHB will not fund sponsorship, donations, gifts and/or corporate hospitality for people inside or outside of the organisation. Exceptions to this rule require prior approval of a Level 3 manager or where the value is greater than \$1000, an ELT member.

In instances where Auckland DHB funds the provision of sponsorship, donations, gifts or corporate hospitality in excess of \$50, Corporate Business Services must be notified. The Corporate Business register records no Auckland DHB gifts, sponsorships, donations or corporate hospitality in excess of \$50.

44. What policies were in place in 2017/18 on giving gifts to staff? How did this compare to the previous financial year? Please list all gifts given to staff exceeding \$100 in value in the 2017/18 financial year. For each, please provide the following details:

- Gift given
- Position of staff member
- Reason given
- Estimated value
- Date given.

Response to Question 44

In 2017/18 Auckland DHB had the following policies regarding the organisation giving gifts to staff:

- Sponsorship, Donations and Corporate Hospitality Policy
- Standards of Conduct Policy
- Expenses – Work Related Policy
- Human Resources Principles Policy – Rewards and Recognition section (page 10)

As a general rule, Auckland DHB will not fund sponsorship, donations, gifts and/or corporate hospitality for people inside or outside of the organisation.

The Human Resources Principles policy defines guidelines for the provision of a consistent process for the management of rewards and recognition for Auckland DHB employees on Individual Employment Agreements (non-clinical staff) to enable the organisation to attract, retain and motivate the right people to achieve delivery of quality healthcare. These guiding principles are based on fair and consistent remuneration.

The policies were the same in the previous financial year.

Gifts given to staff by Auckland DHB exceeding \$100 in value in the 2017/18 financial year.

Generally Auckland DHB do not fund gifts for staff

Flowers are provided to recognise bereavement or staff departures etc. but the total value is less than \$100. These are goodwill gestures rather than gifts.

Question 44 – Appendix 1 Sponsorship, Donations, Gifts and Corporate Hospitality Policy

Question 44 - Appendix 2 Standards of Conduct Policy

Question 44 – Appendix 3 Expenses Personal Work Related

Question 44 – Appendix 4 Human Resources Principles Policy

45. What potential conflicts of interest were identified regarding the board, management or senior staff in 2017/18? For each, please provide the following details:

- Conflict identified.
- Whether or not any contract, policy, consent or other consideration has been entered into with any entity identified in any conflict in the last three financial years.
- Value of any contract, policy, consent or other consideration has been entered into with any entity identified in any conflict in each of the previous three financial years.
- Steps taken to mitigate any possible conflict in granting any contract, policy, consent or other consideration which has been entered into with any entity identified in any conflict in each of the previous four financial years.

Response to Question 45

Auckland DHB has a well socialised and understood conflict of interest policy. All board, management and senior staff complete declarations of their interests which are maintained in a central register. Board members are also asked to confirm their interests and any potential conflicts before each meeting.

Due to the close nature of the health sector in New Zealand potential conflicts do arise from time to time and these are managed in accordance with Auckland DHB's policy and, for board members, within the statutory framework set out in clause 36 of Schedule 3 of the NZ Public Health and Disability Act. The default position is to ensure the potentially conflicted individual is excluded entirely from both discussions and decision-making; this has been the universal approach applied to board members, with their approval.

46. What non-government organisations, associations, or bodies, if any, was your department, agency or organisation a paid member of in 2017/18? For each, what was the cost for each of its memberships? How does this compare to each of the previous four financial years?

Response to Question 46

	In \$s				
Non-Government Organisations	2017/18	2016/17	2015/16	2014/15	2013/14
NZ Coalition to end Homelessness				200	
Planetree	6,847	7,196	7,859	6,061	

The Advisory Board - Nursing	43,788	40,545	36,636	30,357	30,301
The Advisory Board - IT	66,725	62,895	62,895	59,900	59,900
The Advisory Board - Management			43,671	36,738	37,388
The Health Roundtable	125,902	90,503	142,539	132,900	100,551
Volunteering Auckland	649	373	217		
Children's Hospital Association					1,852
NZ Business Excellence Foundation					5,000
Sustainable Business Network Incorp	5,000	2,083			
The Schwartz Centre for Compassionate Healthcare		2,530			
Total	248,911	206,125	293,818	266,156	234,992

47. How many penalties for late payment of an invoice were incurred in the 2017/18 year and what was the total cost of that. How does this compare to each of the previous four financial years?

Response to Question 47

We are not aware of any penalties charged. Our regional accounts payable system and processes ensure that vendors who offer discounts are paid within required timeframes.

48. How many and what proportion of invoices and bills received in the 2017/18 financial year were not paid on time, and how does this compare to each of the previous four financial years?

Response to Question 48

Invoices are processed per our Regional Accounts Payable Policy and Procedures , with two main payments on the 5th and 20th each month. There were no invoices deliberately unpaid on invoice due dates unless there was a commercial dispute, goods were not receipted or Purchase Order reference not quoted. Any missed or urgent invoices were processed outside these main dates.

49. What polls, surveys or market research did your department, agency or organisation undertake in the last financial year and what were the total estimated costs of this work? Please provide a copy of the polling report(s) and the following details. a) Who conducted the work b) When the work commenced c) When it was completed (or due to be completed) d. Estimated total cost e. Whether tenders were invited; if so, how many were received.

Response to Question 49

Auckland DHB's survey programme covers inpatients, outpatients and patients who were seen at, but not admitted to, the Adult Emergency Department (AED).

Each week online survey invitations are sent to eligible patients and the survey results are used to monitor performance and inform service improvement work. An online portal allows staff to review the raw (though anonymised) feedback data.

In 2017/18 a total of \$85,089 was spent on surveying people about their experience of care. (This includes our participation in the HQSC National inpatient survey.) The annual fee for the Auckland DHB inpatient and outpatient surveys have remained the same since the inpatient survey began in 2011 and the outpatient survey began in 2013. These surveys have continued in 2017/18, with the AED survey commencing in July 2016 and a Child Emergency Department Survey also trialled at that time.

From 2011 until 2014 Buzz Channel provided the online survey platform and support/maintenance service. Buzz Channel is now split into two companies – one providing Market Research services and the other providing the online technology, which is called Cemplicity.

We completed a re-tendering of our survey platform through an RFP process in September 2018 to ensure value for money. We are currently transitioning to a new provider. This will influence the 2018/2019 budget but not affect the 2017/2018 financial year.

Patient Experience Survey Reports

In the 2017/18 year, a total of \$86022 was spent on the preparation of in-depth reports about the inpatient and outpatient experience survey feedback (36 reports).

Point Research provides these services. They tendered with Buzz Channel to provide a 'package' of survey software and research report services in 2011 (see above). Point has been providing the reporting services since and has continued to do so into 2017/18. The fee has remained unchanged since the inpatient and outpatient surveys began.

The reports provide a statistical report on the rating of patients' perception of care (e.g. coordination of care, communication, safety, respect and dignity) and thematic analysis about their explanations for those ratings.

The reports are designed to provide analysis in an accessible way and to focus on what matters most to patients so we can improve our care. Organisational reports are published to our website.

As discussed, we have re-tendered for the providers of these services through an RFP process and we are currently transitioning to new providers for commencement in early 2019.

50. How much was spent on advertising, public relations campaigns or publications in the last financial year? How does this compare to the cost of this in the previous four financial years?

Response to Question 50

Auckland DHB's expenditure on advertising is almost entirely spent on listings in the Yellow Pages directories in the Auckland region and on recruitment advertising seeking clinical staff from overseas. The DHB has also provided funding support for public information campaigns on rheumatic fever and syphilis.

Financial year	Advertising and Publication costs
2017/18	\$263,508
2016/17	\$259,711
2015/16	\$406,844

2014/15 \$528,304

2013/14 \$306,796

51. For each advertising or public relations campaign or publication conducted or commissioned in the 2017/18 financial year, please provide the following:

- a. Details of the project including a copy of all communication plans or proposals, any reports prepared for Ministers in relation to the campaign and a breakdown of costs
- b. Who conducted the project
- c. Type of product or service generally provided by the above
- d. Date the work commenced
- e. Estimated completion date
- f. Total cost
- g. Whether the campaign was shown to the Controller and Auditor-General
- h. Whether tenders were or are to be invited; if so, how many were or will be received.

Response to Question 51

Auckland DHB

Advertising	Auckland DHB service listings
Who conducted project	Auckland DHB Communications team
Type of service or product provided	Auckland DHB listing in regions Yellow pages
Date of work	Annual
Estimated completion date	
Total cost	\$39,031 + GST
Campaign shown to Controller/Auditor General	n/a
Whether tenders invited and if so how many received	n/a

Public information campaign	Right Care for You: Encouraging people to access the right support at the right time and avoid unnecessary presentations to ED
Who conducted project	Auckland DHB Communications Team Make Ready Design Agency
Type of service or product provided	Bus Advertising, leaflet drops and social media
Date of work	July/August 2017
Estimated completion date	September 2017
Total cost	\$6,040 +GST
Campaign shown to Controller/Auditor General	n/a
Whether tenders invited and if so how many received	n/a
Public information and stakeholder engagement	Syphilis awareness and community outreach campaign for the Auckland Regional Sexual Health Service
Who conducted project	The AIDS Foundation and Body Positive
Type of service or product provided	Digital advertising including social media, dating apps, and Google advertising. Poster and flyer placement and magazine advertising. Outreach activity including peer educators at venues and drop in centres for

	education and testing
Date of work	December 2018
Estimated completion date	March 2019
Total cost	\$63,988 +GST
Campaign shown to Controller/Auditor General	n/a
Whether tenders invited and if so how many received	Yes, an RFP process was run. Three proposals were received and two of the organisations that submitted proposals (the AIDS Foundation and Body Positive) were funded to deliver a joint campaign.

Auckland Regional Public Health Service (associated agency)

Public relations and stakeholder engagement	Promotion of Good4Work, a new tool that supports workplace wellbeing, to Auckland employers.
Who conducted project	Margo White (contractor)
Type of service or product provided	Engagement with the business community, research and evaluation, business media coverage, creation of communications resources
Date of work	March 2018
Estimated completion date	July 2018
Total cost	\$33,600
Campaign shown to Controller/Auditor General	n/a
Whether tenders invited and if so how many received	n/a
Public relations	Two summary reports from the 2018 Healthy Auckland Together (HAT) Monitoring Report data on obesity, physical activity and nutrition in the region
Who conducted project	Toast (creative digital agency)
Type of service or product provided	Design of two summary reports and separate infographic files for further dissemination.
Date of work	March 2018
Estimated completion date	May 2018
Total cost	\$7,395
Campaign shown to Controller/Auditor General	n/a
Whether tenders invited and if so how many received	n/a

Planning and Funding:

Public information campaign	Rheumatic fever awareness campaign targeting Pacific communities in the ADHB and WDHB catchment area.
Who conducted project	Graham Strategic Ltd
Type of service or product provided	A mixed media campaign using Facebook and Pacific radio stations.
Date of work	September 2017
Estimated completion date	October 2017

Total cost	\$23,744.39 +GST (Note that the total campaign cost was \$47,488.78 which was shared 50/50 between ADHB and WDHB)
Campaign shown to Controller/Auditor General	n/a
Whether tenders invited and if so how many received	Yes. Five tenders were received.

52. How many public relations and/or communications staff, contractors/consultants or providers of professional services were employed in the last financial year; what was the total salary budget for these staff and how much were these staff paid broken down by salary band? How does that compare with each of the previous four financial years? Provide a numerical and percentage breakdown of public relations or communications staff by employment status i.e. permanent, contractor/consultant, provider of professional service.

Response to Question 52

The Auckland DHB communications team provides external and internal communications services.

External functions include management of media enquiries, contribution to OIA responses, communication with patients and their communities, emergency communications (public information management), and the management of the external website and social media channels.

Internal functions include the production of a range of internal newsletters and other communications serving Auckland DHB's 11,000 employees, communications support for changes to the delivery of services and the introduction of new policies and initiatives, management of Auckland DHB's staff awards and other recognition events, and management of the staff intranet.

Auckland DHB Communications

Financial year	Communications FTE	Communications Contractors FTE	Total salary
2017/18	7.13	1.65 project support	\$1,049,032
2016/17 (ref note 1)	7.77	1.47 project support	\$1,301,939
2015/16	4.82	2.1 project support	\$692,030
2014/15	4.90	0.8 project support	\$687,791
2013/14	3.65	0.58 project support	\$419,834

Note 1: The higher cost in 2016/17 was due to the employment of a Director of Communications on contract as part of a stabilisation and turnaround programme for our communications team. This was at a total cost of \$392,302 in FY16/17. In this year we also increased FTE to develop and support our staff intranet, the home for all DHB policies and information for clinical services and guidelines.

Two associated agencies also have communications staff and/or contractors. The Auckland Regional Public Health Service (ARPHS) is Auckland's regulatory public health agency serving the metropolitan Auckland region's diverse populations through health protection, prevention and promotion. ARPHS' communications staff work as part of the Auckland DHB communications team but have a specific

responsibility for regional public health communications work, including outbreak communications, public health campaigns, and management of ARPHS' digital channels.

Auckland Regional Public Health Service (associated agency)

Financial year	Communications FTE	Communications Contractors FTE	Total salary
2017/18	2.60 FTE	1.60 FTE	\$275,025
2016/17	2.58 FTE	1.29 FTE	\$360,229
2015/16	2.52 FTE	1.08 FTE	\$333,509
2014/15	1.91 FTE	1.30 FTE	\$325,647
2013/14	2.42 FTE	0.52 FTE	\$215,220

Organ Donation NZ, the country's official donor agency, provides information on organ and tissue donation and supports donors and families through the donor decision-making process.

Organ Donation NZ (associated agency)

Financial year	Communications FTE	Communications Contractors FTE	Total salary
2017/18	0.5	0	\$39,572
2016/17	1	0	\$45,094
2015/16	1	0	\$50,904
2014/15	1	0	\$57,356
2013/14	1	0	\$56,286

53. How much was spent in 2017/18 on merchandise/promotional products (apparel, stationery, pen drives etc.) carrying the branding of your department, agency or organisation or its campaigns, policies or marketing? How did this compare to each of the previous four financial years? For each invoice over \$1,000 in 2017/18 please provide the item purchased, the amount purchased, costs and the intended use.

Response to Question 53

The total cost of merchandise/promotional products in 2017/18 was \$51,163. This is similar to the amounts spent on merchandise in the previous four years.

Product	Cost	Purpose
Financial year 2017/18		
2000 Auckland DHB Water Bottles	\$14,596	Branded water bottles are given to new staff joining the DHB as part of on-boarding and help reduce the volume of disposable

		cups the DHB sends to landfill.
5000 Auckland DHB: Lanyards	\$10,060	5000 branded lanyards and clips were produced in this financial year for Auckland DHB staff to safely carry their ID and security cards.
To Thrive – Branded bags, information cards and Water Bottles	\$7,327	To Thrive is a programme that supports our low paid workforce. Branded bags, information cards and water bottles are provided to the participants.
400 Values T- Shirts	\$3,980	T-shirts in a range of sizes are lent to staff who are representing Auckland DHB at events such as Pink Shirt Day. They are branded with the Auckland DHB values: Welcome, Haere Mai; Respect, Manaaki; Together, Tuhono; and Aim High, Angamua.
800 Immunisation T- Shirts	\$15,200	As part of our immunisation work programme, "Hugs not Bugs - Immunise" branded t-shirts were distributed to primary care practices and other immunisation providers.

54. How many press releases, if any, were released in the 2017/18 financial year? How many were released in each of the previous four financial years?

Response to Question 54

Financial Year	Number of press releases
2017/18	22
2016/17	29
2015/16	24
2014/15	25
2013/14	26

55. In 2017/18, did your department, agency or organisation have an internal group of staff whose primary role was to support the Minister or their Office by processing information requests such as Parliamentary questions, Official Information Act requests, and ministerial correspondence; if so, what is the name of that group, how many staff were in the group, what was the cost of this, and where were they located? What were these numbers for each of the previous four financial years?

Response to Question 55

Official Information Act Requests:

In 2017/18 Auckland DHB did not have an internal group of staff whose primary role was to provide support in processing information requests. This role was shared by a variety of staff from multiple parts of the organisation each of whom held responsibility for different parts of the process. These include:

- Team Administrator, Corporate Business Services
- Corporate Committee Administrator
- Corporate Governance Manager

- Corporate Business Manager
- Chief Executive
- Director of Communications and Stakeholder Engagement
- Communications Manager – External & Media
- General Legal Counsel
- Chief Health Professions Officer
- The relevant Executive Director to lead the response (determined by the subject matter of the request).
- Officer responsible for drafting the response (also determined by the subject matter of the request)

Involvement of these staff in Official Information Act requests was variable dependent on the nature and subject matter of each Official Information Act request received.

There are no staff dedicated solely to this role. It is seen as a shared responsibility for senior staff.

Ministerial Requests:

Requests that are received outside of the Official Information Act Request process were generally received by the Auckland DHB Board Chair or the Chief Executive.

The subject matter of the request determined whom and how many staff were involved in preparing this information.

Location of Staff: The majority of staff involved were located at Auckland DHB's Grafton and Greenlane sites.

Costs: Because of the variability of the involvement of our senior staff in OIA responses, we are unable to supply information on costs.

56. What was the number of Official Information Act Requests received, responded to within 20 working days, responded to after 20 working days, transferred, and declined during 2017/18? What were these numbers for each of the previous four financial years?

Response to Question 56

	2017/2018	2016/2017	2015/2016	2014/2015	2013/2014
Number of Official Information Act requests received	223	225	103	167	142
Number responded to within 20 days	194	211	88	142	117
Number responded to after 20 days	29	14	14	24	24
Number transferred	9	11	1	1	1
Number declined	23	5	7	15	2

57. What was the average response time for Official Information Act Requests during 2017/18? What was this number for each of the previous four financial years?

Response to Question 57

The average Auckland DHB response time for Official Information Act requests was:

Year	Average OIA Response Time (Working Days)
2013/2014	13.6
2014/2015	11
2015/2016	16.5
2016/2017	18.6
2017/2018	17.6

58. How many complaints were received under the Privacy Act or Official Information Act during 2017/18 broken down by whether each has been upheld, dismissed, or still under investigation? How does this compare to each of the previous four financial years?

Response to Question 58

Auckland DHB received three complaints under the Official Information Act during the 2017/18 financial year.

Of those three, all were withdrawn.

There were approximately five complaints to the Ombudsman about Auckland DHB's OIA responses in the previous four years. All were resolved with the assistance of the Ombudsman.

Privacy complaints are handled as one type of patient complaint. Most are addressed directly with the patient; during 2017/2018 Auckland DHB received no complaints via the Office of the Privacy Commissioner.

59. What policies are in place for Official Information requests to be cleared by or viewed by the Minister's office? Have any of these policies changed since the new Government was sworn in?

Response to Question 59

The Auckland DHB's Official Information Act Policy states we will forward Official Information Act requests to the Ministers office:

"Section 4.2 Corporate Business Manager to forward copy of request to Director of Communications, Chief Health Professions Officer, Board Chair, Minister of Health's Office, Ministry of Health Sector OIA's inbox and Ministry of Health DHB Relationship Manager"

Auckland DHB complies with the State Services Commission "no surprises" approach where a Government expects the Auckland DHB Board to:

- Be aware of any possible implications of their decisions and actions for wider government policy issues.

- Advise the responsible minister of issues that may be discussed in the public arena or that may require a ministerial response, preferably ahead of time or otherwise as soon as possible.
- Inform the minister in advance of any major strategic initiative.

All Official Information Act requests are logged with the Connex system operated by DHB Shared Services to enable individual DHBs to be aware of clarifications and changes to requests. See also to our response to Question 55.

These policies have not changed since the new government was sworn in.

60. Does your department, agency or organisation have specific policies or procedures that apply to requests for information from media, bloggers, political parties, or OIAs deemed 'high risk' which differ to those for regular requests; if so, please provide full details of those policies?

Response to Question 60

Auckland DHB responds to requests for information from media and bloggers according to the Auckland DHB media policy. All official information requests are managed in accordance with the Official Information Act.

We do not have specific policies for requests for information from political parties, or OIAs deemed 'high risk'.

Every effort is made to accurately answer each and every request submitted and to be as transparent as possible with our information.

61. What instructions or directions from Ministers or their staff regarding the processing or handling of Official Information Act requests did the agency or organisation receive during 2016/17?

Response to Question 61

As noted in our response to Question 54, there is an agreed standing protocol with the Ministry of Health that Auckland DHB forward any relevant OIA's from Parliamentary representatives and/or media, and OIA requests of particular public interest on receipt to the sector OIA's inbox.

62. Were any privacy issues identified in the 2017/18 financial year and in the previous four financial years? If so, what were they and what are the titles of any reports into them?

Response to Question 62

Auckland DHB and other DHBs has been working with the Government Chief Privacy Officer, the Office of the Privacy Commissioner and Ministries to be both compliant with its privacy obligations and aligned with an all-of-government approach to privacy. This approach has been aimed at concepts such as 'Privacy by design' being embraced by the Auckland DHB. Individual privacy related incidents linked to structural issues have recently been added to the ADHB incident management system, Datix. Individual privacy breaches will be address and reported to the Information Governance and Privacy Group (IGPG) Meeting.

63. How many staff positions in the policy area were left unfilled in the 2017/18 financial year broken down by policy area in total? How did that compare with each of the previous four financial years? How is the agency or organisation continuing to carry out work in the absence of staff in these positions?

Response to Question 63

As at the end of the 2017/18 financial year, Auckland DHB had 732 unfilled positions identified or underway for recruiting. The table below shows a breakdown of unfilled positions by occupational group and a comparison to the previous four financial years. The figures vary year-by-year depending on turnover levels and variation in roles being advertised. Most clinical and direct support roles by necessity are covered by temporary staff while recruitment takes place.

Occupational Group	2017/18	2016/17	2015/16	2014/15	2013/14
Administration	74	87	64	105	98
Bureau/Agency	0	1		16	12
Healthcare Assistants	47	27	12	15	16
Hotel	4	0	0	5	5
Medical	117	91	86	92	91
Nursing	310	226	247	256	243
Technical Patient Care	163	158	117	173	152
Technical Support	17	33	23	28	40
Grand Total	732	623	549	690	657

64. How many permanent staff were employed within your department, agency or organisation during the last financial year? How does this compare to each of the previous four financial years?

Please breakdown by:

- Role (e.g. policy/admin/operational)
- Classification (full and part-time)
- Office (e.g. geographical location)

Please provide detailed explanations for any fluctuations in staff numbers of plus or minus 10%.

Response to Question 64

The following tables show the number of permanent staff employed at Auckland DHB as at the end of the last five financial years. The year by year increase in the headcount indicates increased levels of service demands requiring increased staffing to achieve better outcomes. The increase in staff at Other Community Service Centres during the 2017/18 year reflects an improvement in data, rather than any real change in operations.

Occupational Group	2017/18	2016/17	2015/16	2014/15	2013/14
Administrative	1391	1277	1290	1245	1223
Household	354	285	279	263	380
Medical	969	928	904	876	819
Nursing	4173	3928	3865	3721	3658
Stores	0	0	0	0	0

Technical Patient Care	975	975	935	901	895
Technical Support	1118	1116	1113	1098	1060
Grand Total	8980	8509	8386	8104	8035

Status	2017/18	2016/17	2015/16	2014/15	2013/14
Full Time	4955	4681	4639	4472	4464
Part Time	4025	3828	3747	3632	3571
Grand Total	8980	8509	8386	8104	8035

Location	2017/18	2016/17	2015/16	2014/15	2013/14
Auckland City Hospital	5646	5602	5544	5438	5439
Greenlane Clinical Centre	1844	1780	1699	1437	1413
Starship Children's Hospital	1033	959	972	931	889
Other Community Service Centres	457	168	171	124	113
Unspecified	0	0	0	174	181
Grand Total	8980	8509	8386	8104	8035

65. Please provide a breakdown by role (e.g. policy/administration/operational) and location of the agency or organisation's staff numbers in 2017/18 and each of the previous four financial years, by age and gender.

Response to Question 65

	2017/18		2016/17		2015/16		2014/15		2013/14	
Occupational Group	Female	Male								
Administration	1158	233	1069	208	1071	219	1037	208	1028	195
Household	233	121	182	103	182	97	168	95	258	122
Medical	453	516	419	509	391	513	362	514	332	487
Nursing	3736	437	3526	402	3482	383	3362	359	3326	332
Technical Patient care	816	159	807	168	771	164	735	166	728	167
Technical Support	764	354	765	351	768	345	764	334	737	323
Total	7160	1820	6768	1741	6665	1721	6428	1676	6409	1626

Year end	Age	Admin	House-	Medical	Nursing	Technical	Technical
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	Group		hold			Patient care	Support
2017/18	<=20	1	1		4	1	2
	21-30	129	34	7	1165	204	233
	31-40	257	61	169	1043	271	287
	41-50	337	86	359	837	215	253
	51-60	409	112	285	796	203	237
	61+	258	60	149	328	81	106
2016/17	<= 20	8	2	1	13	1	1
	21-30	78	11	2	1044	204	215
	31-40	234	46	157	912	264	286
	41-50	319	70	347	869	217	273
	51-60	398	102	283	782	209	244
	61+	240	54	138	308	80	97
2015/16	<= 20	11	2	1	14		3
	21-30	88	14	3	957	170	197
	31-40	244	46	141	900	253	292
	41-50	313	70	347	925	224	285
	51-60	390	98	281	768	210	239
	61+	244	49	131	301	78	97
2014/15	<= 20		4		2		1
	21-30	78	16	3	913	151	192
	31-40	220	40	133	767	238	288
	41-50	332	62	336	969	220	299
	51-60	372	94	278	784	210	218
	61+	243	47	126	286	82	100
2013/14	<= 20	2	2				3
	21-30	70	26	2	865	169	206
	31-40	212	68	134	808	228	264
	41-50	341	94	321	965	228	287
	51-60	368	126	260	761	196	213
	61+	230	64	102	259	74	87

66. If your agency or organisation has a cap on the number of Full Time Equivalent (FTE) positions in 2017/18, what was the figure at which it was capped? How many FTEs were employed in 2017/18, and how does this compare to each of the previous four financial years?

Response to Question 66

The table below shows Actual FTE for the past five financial years.

The total annual budgeted, rather than capped, FTE for the financial year 2017/18 was 8951.55. Actual FTE usage for the financial year remained favourable to budget with a variance of 60.27 FTE.

	2017/18	2016/17	2015/16	2014/15	2013/14
Actual FTE as at end of each Financial Year	8,891	8596	8477	8348	8028

67. How many of the total staff employed are considered to be frontline staff and how many are considered back office staff (both in nominal terms and as a percentage of total staff) and how does that number compare to the number of frontline and back office staff in each of the past four financial years?

Response to Question 67

The table below shows the percentages of frontline and back office staff as a percentage of total staff. Please note: casuals and fixed terms are included below.

Staff occupation groups such as, medical, nursing and allied health and technical groups who have interaction with patients and provide essential clinical services, are grouped in the frontline category. Other occupational groups such as administrative and support are grouped in back office staff. The total head count is as follows:

	2017/18		2016/17		2015/16		2014/15		2013/14	
Category	Total	%								
Frontline staff	8923	82%	8857	83%	8709	83%	8320	81%	8103	81%
Back office staff	1878	17%	1730	16%	1722	16%	1914	18%	1850	18%

68. How many contractors, consultants, including those providing professional services, were engaged or employed in 2017/18 and what was the estimated total cost? How did this compare to each of the previous four financial years, both in terms of the number engaged and the total cost? For each consultant or contractor that has been engaged in the previous four financial years please provide the following details:

- Name of consultant or contractor
- Type of service generally provided by the consultant or contractor
- Details of the specific consultancy or contract
- Budgeted and/or actual cost
- Maximum hourly and daily rates charged
- Date of the contract
- Date the work commenced
- Completion date
- Whether tenders were invited; if so, how many were received
- Whether there are proposals for further or following work from the original consultancy; if so, the details of this work?

Response to Question 68

Summary of spend on contractors and consultants are provided below:

Financial Year Contractor Costs

2017/18 \$8,969,525

[Details of this expenditure are contained in Question 68 – Appendix 1](#)

69. Were any contracts awarded in the last financial years which were valued at \$1 million or more? If so, please list by name of company contracted and total value of contract. How did this at compare with each of the previous four financial years?

Response to Question 69

Company	2013/14	2014/15	2015/16	2016/17	2017/18
Argon Construction Ltd	\$1,396,836				
Argon Construction Ltd	\$3,005,157				
Argon Construction Ltd	\$8,873,666				
Asaleo Care New Zealand Limited					\$971,902
Asaleo Care New Zealand Limited					\$791,419
Asaleo Care New Zealand Limited					\$574,380
Auckland Co-op Taxi Society Ltd					\$1,316,129
Auckland Eye Limited					\$2,151,100
Brosnan Construction		\$6,719,988			
Canam Construction	\$9,800,000				
Ebert Construction		\$6,936,141			
Fertility Associates	\$1,198,157				
Fertility Associates	\$3,268,934				
Hawkins Construction Ltd	\$2,049,717	\$2,425,248			
Ideqa Limited					\$2,554,260
Invacare New Zealand					\$1,317,231
Madison Recruitment Ltd & Madison Force Ltd	\$2,800,000				
McMurray Institute Ltd			\$1,620,000		
Multiple Share Mgmt Suppliers					\$5,009,246
NZ Strong Construction		\$4,410,000			
Onelink					\$1,564,000
Phillips New Zealand Limited	\$2,650,000				
RCC Healthcare Ltd	\$14,767,264				
Repromed Auckland Limited	\$3,425,036				
Robert Cunningham Construction		\$11,189,936	\$2,183,951		
Company	2013/14	2014/15	2015/16	2016/17	2017/18
1st Maintenance Limited		\$377,699	\$386,451	\$869,786	\$1,148,497
Allendale Electrical		\$1,132,048	\$1,157,054	\$1,114,785	\$1,000,369
Alliance Health Plus	\$1,371,382				

Ask Metro Ltd	\$1,177,535	\$1,194,352			
Auckland PHO Limited	\$1,587,245				
Chenery Contracting Ltd		\$790,737	\$766,102	\$795,308	\$1,050,758
Contact Energy				\$434,046	\$1,052,838
Emerge Aotearoa Limited			\$1,798,606		
First Security		\$1,024,787			
Genesis Energy Ltd	\$2,057,913	\$2,258,939	\$1,996,029	\$2,156,787	\$2,300,293
Meridian Energy Ltd	\$1,853,564	\$1,947,960	\$1,957,911	\$1,222,232	
PAE (New Zealand) Ltd	\$1,171,634	\$1,279,791	\$1,288,612	\$2,408,310	\$2,247,521
Pioneer Generation Ltd	\$4,058,571	\$3,978,021	\$3,003,965	\$3,572,143	\$4,610,331
Royal New Zealand Plunket Society		\$1,661,331			
Vector Limited	\$883,636	\$1,012,016	\$1,056,091	\$779,245	\$984,212
Watercare Services Ltd	\$1,565,184	\$1,592,607	\$1,640,578	\$1,493,038	\$1,446,676 Bottom of Form

70. What is the policy of your department, agency or organisation on the use of consultants, contractors or people providing professional services as opposed to regular employees? Has this policy changed in the last financial year, if so, why and how?

Response to Question 70

Under the Auckland DHB policy (The engagement of Contractors and Consultants) contractors/consultants are normally engaged where there is an expectation using external resources will meet unique needs, achieve cost savings, or provide a higher quality of service than using in-house staff. This may occur in the following situations:

- *Specialised expertise or skill:* Certain types of expertise or skills may not be available internally and Auckland DHB may not consider it feasible or desirable to gain the skills through internal training or recruitment.

- *An external or unbiased opinion:* Auckland DHB may wish to have an independent evaluation, review or judgement that is not affected by internal considerations or influenced by past events.

- *External advice to management:* At critical stages, Auckland DHB may wish to take external advice, for example, at times of organisation change.

- *To undertake work quickly:* Auckland DHB may need to boost its internal resources by engaging a consultant to help expedite business processes or to complete projects more quickly.

- *Staff training:* Auckland DHB may find it impractical to train its staff comprehensively using its own resources. A consultant could therefore be engaged to undertake aspects of training.

The policy was reviewed in 2017 and was not changed.

71. How many consultants, contractors or people providing professional services contracted in 2017/18 were previously employed permanently within your department, agency or organisation during the previous two financial years broken down by whether they had received a redundancy payment, severance or other termination package or not? How many contractors hired in each of the previous four financial years had previously been permanent employees in the agency or organisation in the previous two financial years?

Response to Question 71

We have not been able to identify consultants or contractors who were previously staff.

72. Were any consultants, contractors or agencies contracted to provide communications, media or public relations advice or services in the 2017/18 financial year; if so, with whom did they contract, what was the specific purpose or project, for what length of time and at what total actual or estimated cost? How does this compare to each of the previous four financial years?

Response to Question 72

In 2017/18 Auckland DHB communications used the services of 1.65 FTE (primarily sole traders), at a total cost of \$173,881.79

Contractor	Range	Project details
Anneke Bodde	Under \$20,000	General communications support.
Helen Hayes	Under \$90,000	Communications support for Auckland Regional Public Health Service including outbreak management.
Jennifer Dann	Under \$20,000	Management of media enquiries during weekends and public holidays.
Jodie Green	Under \$5000	General communications support.
Kate Voice	Under \$5000	General communications support.
Kirsty Jones	Under \$40,000	Management of media enquiries during weekends and public holidays and general communications support.
Lexicon	Under \$5,000	General communications support.
Stephanie Mello	Under \$10,000	General communications support.
Zoe Garrett	Under \$30,000	Communications support for staff recognition events (supported through a grant from the A+ Trust).
Grand Total	\$173,881.79	

Where the table indicates 'General communications support', detailed information for these contractors is not readily available. However, contractors were used for a range of services including project support and where specific expertise was required such as photography, video production, proof reading, copy writing or web development.

Associated service the Auckland Regional Public Health Service had 0.40 FTE communications contractors (total cost = \$80,219) to provide vacancy cover and project support, including support for outbreak management and projects requiring digital expertise.

Last four financial years	Communications Contractors FTE	Costs
2016/17	1.47 project support	\$153,448.57
2015/16	2.1 project support	\$152,231.94
2014/15	0.8 project support	\$65,963.49
2013/14	0.58 project support	\$49,843.30

Please refer also to our answer to Question 52.

73. How many temporary staff were contracted by your department, agency or organisation in the 2017/18 financial year, listed by purpose of contract, name of company or individual contracted, duration of temporary staff's service, hourly rate of payment and total cost of contract?

Response to Question 73

Please refer to our response to Question 75.

74. How many staff were hired on each of the following contract lengths: three-month or less, three-to-six month, or six-to-nine month in the 2017/18 financial year? How does this compare to the number hired on each of these contracts in each of the previous four financial years?

Response to Question 74

At Auckland DHB, staff are employed on fixed term contracts for project work or parental leave (or other absence) cover. The table below shows the number of fixed term staff started over each of the past four financial years and broken down by contract duration requested. The numbers exclude Resident Medical Officers (Junior Doctors) who are on a fixed term employment agreement for the duration of their training.

Duration of fixed-term contract	2017/18	2016/17	2015/16	2014/15	2013/14
Less than 3-month	15	2	0	1	3
3 to 6 month	12	14	9	12	12
6 to 9 month	23	18	11	20	12

75. How many staff were employed on a fixed term contract in total in 2017/18? How does this compare to each of previous four financial years?

Response to Question 75

The table below shows the number of fixed-term staff that Auckland DHB employed as at end of each of the past five financial years. The numbers exclude Resident Medical Officers (Junior Doctors) who are on a fixed term employment agreement for the duration of their training. The fixed term employee headcount has decreased by 15% in the financial year 2017/18 compared with the previous year, 2016/17.

	2017/18	2016/17	2015/16	2014/15	2013/14
Number of Fixed Term staff	510	599	630	506	407

76.

How many staff were hired in the last financial year whose contracts included a 90-day probationary period? Please provide a breakdown by role.

Response to Question 76

The Auckland DHB has not employed any staff on contracts which included a 90-day probationary period in the last financial year.

77. Please provide a summary of any collective employment agreement negotiations completed in the 2017/18 financial year including the cost of that, and an outline and timeline of negotiations to be conducted in 2018/19?

Response to Question 77

The cost of all settlements nationally has been over the **2.43%** annualised increase agreed by the 20 DHB CEOs and the ERSG. The average cost for Auckland DHB has been over 3% annualised. The benchmark for these settlement costs was set by the NZNO Nurses MECA following industrial action.

Collective employment agreement negotiations completed in 2017/18:

- NZNO Nurses and Midwives MECA
- Etu Service Workers MECA
- PSA Allied, Scientific and Technical MECA
- PSA Public, Mental Health and Community Nurses MECA
- APEX Perfusionists SECA
- SToNZ Resident Medical Officers MECA

Collective eemployment agreement negotiations to be completed in 2018/19 cover:

- MERAS Midwives - MECA Expired 31 July 2017- Negotiations on going
- FIRST Service workers, Orderlies and Health Care Assistants – SECA expired April 2018 - Negotiations on going
- PSA Clerical and Administrative – MECA expired March 2018 - Pay Equity work not complete
- NZRDA Resident Medical Officers – MECA expired Feb 2018- Negotiations on going
- APEX Auckland Audiologists – SECA expired March 2018 - Settlement offer tabled 28 November 2018
- MLWU National Medical Laboratory Workers - MECA expires September 2019
- APEX Psychologists - MECA expires February 2019
- APEX Psychotherapists - New SECA initiated
- APEX Medical Radiation Technologists - MECA expires February 2019
- APEX Medical Physicists - MECA expired August 2018
- APEX Radiation Therapists - MECA expires April 2019
- APEX Clinical Physiology - MECA expires December 2019

78. How many staff were on collective and individual employment agreements respectively in the last financial year? How does this compare with the numbers of staff on collective and individual employment contracts for each of the previous four financial years?

Response to Question 78

The table below includes headcount by agreement as at the end of 2017/18 financial year (excluding casual staff and contractors). Significant work has been performed during the 2017/18 financial to identify employees that are on derived IEAs.

	2017/18 Year End	2016/17 Year End	2015/16 Year End	2014/15 Year End
Collective Employment Agreements	9255	9253	9073	8496
Derived Individual Employment Agreements (i.e. covered by collective terms and conditions but not an official union member)	207	64	82	155
Individual Employment Agreements	627	584	579	475
Total	10089	9901	9734	9126

79. Were any specific instructions, directions or advice received in relation to employment agreement matters from the State Services Commission or responsible Minister in the 2017/18 financial year? If so, please provide details.

Response to Question 79

Auckland DHB has not directly received any specific instructions, directions or advice from the State Services Commission and responsible Minister in relation to any Auckland DHB employees. All instructions come to us via the Ministry of Health and Central TAS. The State Services Commission has provided specific instructions in relation to the process to have the annual review of the Chief Executive's performance and remuneration review completed and approved.

80. How many days of annual leave did employees have accrued on average during 2017/18? How does this compare to each of the previous four years? What strategies are used to encourage employees to reduce annual leave balances?

Response to Question 80

The table below shows the average days of annual leave accrued by Auckland DHB employees as at the end of each of the past five financial years.

Staff health and wellbeing is the key focus at Auckland DHB. Managers are provided with tools and data to proactively monitor staff annual leave balances so that they can regularly encourage them to take time-off for rest and recuperation.

Days of Annual Leave Accrued

FY	Average Days
2017/18	20.16
2016/17	20.59

2015/16	21.42
2014/15	24.16
2013/14	24.04

81. How many annual leave applications did the agency or organisation cancel or refuse during 2017/18? How does this compare to each of the previous four financial years?

Response to Question 81

Cancellation or refusal of annual leave applications is not recorded at Auckland DHB.

82. How many employees sold their fourth week of annual leave in the 2017/18 financial year? How does this compare to each of the previous financial years since this policy came into effect?

Response to Question 82

The data in the table below has been extracted from employee records of Annual Leave Buyout. As there is no accurate way of determining whether the leave bought is the 4th, 5th or 6th week of annual leave entitlement, all Annual Leave Buyout has been included. (This change in methodology means that previous years' submissions may differ from the previous years' data provided below).

Sold fourth (+) week of annual leave		
Financial Year	Staff Count	Actual Hours
2017/2018	116	15957
2016/2017	202	23970
2015/2016	219	27493
2014/2015	282	35363
2013/2014	183	23343
2012/2013	198	42341

83. How many days of sick leave did employees take on average during 2017/18? How does this compare to each of the previous four financial years? What strategies are used to reduce the amount of sick leave employees need to take?

Response to Question 83

Auckland DHB has a regular programme of wellness activity and education, including free flu injections, subsidised gym membership; access to hand sanitizer, mindfulness-based stress reduction training, five ways to wellbeing (Mental Health) training and other initiatives.

Average sick leave taken

FY	Total Hours sick leave taken	Average days per person
2017/2018	581089	6.78
2016/2017	560058	6.65

2015/2016	542205	6.51
2014/2015	539683	6.99
2013/2014	524136	7.01
2012/2013	517320	7.11

84. How much was spent on EAP or workplace counselling in the 2017/18 financial year and how did that compare to each of the previous four financial years?

Response to Question 84

	FY2013/14	FY2014/15	FY2015/16	FY16/17	FY17/18
EAP cost	94,853	165,498	129,146	179,845	176,181

85. What was the number and cost of staff seconded to Ministerial offices during 2017/18 and how many of these had their salaries paid by the department, agency or organisation rather than Ministerial Services? What were these numbers in each of the previous four financial years? For each staff member seconded, please provide the following details:

- How long they were seconded for (less than 6 months, 6-12 months, 12-24 months or 24 months or more);
- The role they were seconded to;
- The role they were seconded from;
- The reason for the secondment;
- The remuneration they have received over and above the remuneration they are contracted for in the role they have come from.

Response to Question 85

There are no records of any staff seconded to Ministerial offices and associated agencies from Auckland DHB.

86. What was the turnover rate of staff seconded to Ministerial offices from the agency or organisation during 2017/18 and what was it for each of the previous four financial years?

Response to Question 86

There are no records of any staff seconded to Ministerial offices and associated agencies from Auckland DHB.

87. Has your department, agency or organisation covered any travel or accommodation costs for any staff seconded from one role to another in 2017/18; if so, what was the total cost for each secondment, broken down by type of expenditure? How does this compare to the previous three financial years?

Response to Question 87

Travel and accommodation costs recorded cannot be differentiated between whether they were incurred due to staff being seconded from one role to another or incurred due to general business expenses. Therefore, this information is not provided.

88. What was the staff turnover for 2017/18 and what was the staff turnover for each of the previous four financial years by category? Please provide this information both as a percentage and

in numerical terms. Is the turnover rate cause for any concern, if so, what are the major issues and how will these be addressed in 2018/19?

Response to Question 88

Auckland DHB's turnover percentages for the past five years are given below. Note, in keeping with the Ministry of Heath definition, RMOs, casuals, fixed-terms and contractors are excluded.

	2017/18	2016/17	2015/16	2014/15	2013/14
Total Number of Resignations	1138	1092	987	826	774
Total Turnover	12.0%	12.40%	10.80%	10.00%	9.50%

89. What was the average length of service in your department, agency or organisation in the 2017/18 financial year and each of the previous four financial years? Please also provide this information broken down by age and gender.

Response to Question 89

The tables below show average tenure of permanent employees in the past five financial years.

	2017/18	2016/17	2015/16	2014/15	2013/14
Average of Tenure in years	7.56	7.75	8.80	8.56	8.72

Average Length of Service – A Breakdown by Gender

Gender	2017/18	2016/17	2015/16	2014/15	2013/14
Female	7.48	7.69	8.77	8.39	8.51
Male	7.88	7.96	8.89	9.19	9.53
Gender not disclosed				0.55	
Grand Total	7.56	7.75	8.80	8.56	8.72

Average Length of Service – A Breakdown by Age group

Age Group	2017/18	2016/17	2015/16	2014/15	2013/14
16-19	0.18	2.08	3.24	0.55	0.47
20-29	1.73	1.80	2.83	2.42	2.55
30-39	3.74	4.13	5.25	5.3	5.33
40-49	7.95	8.07	9.04	8.57	8.57
50-59	11.81	12.09	12.82	12.26	12.35
60-69	17.32	16.85	17.92	17.15	17.38
70+	18.22	19.32	20.89	22.64	22.96
Grand Total	7.56	7.75	8.80	8.97	8.99

90. How many staff resigned during 2017/18, what were the reasons provided, and what are the possible implications for the agency or organisation? Please also provide the number broken down by age and gender.

Response to Question 90

As indicated in question 90, the total number of resignations is 1139, with 1071 voluntary resignations, and 68 involuntary resignations. The tables below show a breakdown by resignation reasons.

The table below shows the breakdown by gender and age group.

Voluntary Resignations	Headcount
Left District	175
To Go Overseas	117
Personal	112
Another Job In Public Health	188
Family Reasons	74
Retire	105
Job In Private Health	105
New Job	17
Job Outside Health	57
No Reason	71
To Further Education	24
Job Dissatisfaction	16
Dissatisfaction With Board	6
Abandoned Employment	4
Grand Total	1071
Involuntary Resignations	Headcount
Ill Health	33
Redundant	22
Dismissed	5
Deceased	8
Grand Total	68

	Female	Male	Grand Total						
No. of Resignations	924	215	1139						
	16-19	20-29	30-39	40-49	50-59	60-69	70+	Unknown	Total
No. of Resignations	1	303	287	218	186	122	21	1	1139

91. How many people received and how much was spent in total on redundancy payments, severance or other termination packages by the agency or organisation in the 2017/18 financial year? How does that compare to the number and amount spent in each of the previous four financial years?

Response to Question 91

Redundancy and severance payments

Period	Payment	Staff	Amount
2017/18	Redundancy	23	\$1,391,459.27
2016/17	Redundancy	8	\$242,508.00
2015/16	Redundancy	12	\$299,546.72
2014/15	Redundancy	13	\$385,769.25
2013/14	Redundancy	14	\$496,519.86

92. How much, in \$10,000 bands, of all individual total amounts, was paid out in redundancy, severance or other termination packages in the 2017/18 financial year? How does this compare to the individual total amounts paid out in redundancy, severance or other termination packages in each of the previous four financial years?

Response to Question 92

Redundancy and severance payments with \$10K banding reported

Period	Payment	Staff	Amount	BAND
2017/18	Redundancy	23	\$1,391,459.27	
	Redundancy	1	\$6,407.00	0-10K
	Redundancy	3	\$48,673.83	10-20K
	Redundancy	2	\$45,489.00	20-30K
	Redundancy	2	\$67,991.00	30-40K
	Redundancy	3	\$144,449.59	40-50K
	Redundancy	1	\$57,373.37	50-60K
	Redundancy	3	\$194,421.30	60-70K

	Redundancy	1	\$70,419.18	70-80K
	Redundancy	5	\$413,129.20	80-90K
	Redundancy	1	\$92,110.48	90-100K
	Redundancy	1	\$250,995.32	250-260K
2016/17	Redundancy	8	\$242,508.00	
	Redundancy	3	\$18,159.00	0-10K
	Redundancy	1	\$10,285.92	10-20K
	Redundancy	2	\$46,059.68	20-30K
	Redundancy	1	\$68,233.09	60-70K
	Redundancy	1	\$99,770.31	90-100K
2015/16	Redundancy	12	\$299,546.72	
	Redundancy	2	\$5,861.16	0-10K
	Redundancy	4	\$60,970.01	10-20K
	Redundancy	3	\$71,024.38	20-30K
	Redundancy	1	\$39,413.00	30-40K
	Redundancy	1	\$47,385.36	40-50K
	Redundancy	1	\$74,892.81	70-80k
2014/15	Redundancy	13	\$385,769.25	TOTAL
	Redundancy	4	\$68,451.95	10-20K
	Redundancy	4	\$101,160.36	20-30K
	Redundancy	3	\$99,523.92	30-40K
	Redundancy	1	\$52,762.16	50-60K
	Redundancy	1	\$63,870.86	60-70K
2013/14	Redundancy	14	\$496,519.86	TOTAL
	Redundancy	1	\$7,885.60	0-10K
	Redundancy	3	\$43,483.15	10-20K
	Redundancy	2	\$52,291.22	20-30K
	Redundancy	4	\$132,695.00	30-40K
	Redundancy	2	\$83,624.65	40-50K
	Redundancy	1	\$78,972.00	70-80K
	Redundancy	1	\$97,568.24	90-100K

93. How much was spent on performance bonuses, incentive payments or additional leave in 2017/18 and each of the previous four financial years? Please provide a breakdown of the number of bonuses received during 2017/18 in \$5,000 bands. What were the specific criteria for such performance payments? Has there been any changes to the criteria since November 2008; if so, what specific changes and why?

Response to Question 93

All bonus payments were performance related and contractual. No changes to criteria for aforementioned contracts.

FY	\$5K BANDS	NUMBER	TOTAL
2013/2014	45-50	2	\$ 96,269
2014/2015	50-55	1	\$ 49,777
2014/2015	60-65	5	\$ 300,000
2014/2015	75-80	1	\$ 76,950
2015/2016	45-50	1	\$ 47,028
2015/2016	50-55	1	\$ 50,175
2015/2016	90-95	5	\$ 450,000
2016/2017	20-25	1	\$ 20,000
2016/2017	30-35	1	\$ 32,478
2016/2017	35-40	1	\$ 39,055
2016/2017	50-55	1	\$ 50,225
2016/2017	120-125	5	\$ 600,000
2017/2018	30-35	1	\$ 30,000
2017/2018	105-110	1	\$ 108,576
2017/2018	120-125	5	\$ 600,000

One employee received two payments during FY2017/2018 (\$52,501 linked to FY2016/2017 performance and \$56,075 linked to FY2017/2018 performance).

Performance bonus scheme payments for group of 5 employees represented two quarters achievement in FY2014/2015, three quarters achievement in 2015/2016 and four quarters achievement in FY2016/2017 and FY2017/2018.

94. In \$10,000 bands, what are the salary levels of all staff, and how does this compare with the salary levels for each of the previous four financial years? Please also provide this information by age and gender.

Response to Question 94

Attached document includes 2 tables for each of the previous 5 FYS

95. How much was spent on catering in the 2017/18 financial year? What policies were in place for the use of catering and were there any changes to these?

Response to Question 95

The total catering spend for 2017/18 financial year was \$207,628 of which \$140,137 (67.49%) was purchased from in-house nutrition service or staff cafes operated by Auckland DHB.

Auckland DHB has two policies that refer to the use of catering. They are the Travel Policy and Work Related Expense policy. There has been no change to these policies in the 2017/18 financial year.

96. How much was spent on domestic travel in the 2017/18 financial year and how does this compare to each of the previous four financial years? Provide a breakdown of spending on airfares, taxis/UBER and rental cars. Please provide a list of the positions of the top twenty spenders on domestic travel for 2017/18 including the amount spent.

Response to Question 96

Year Domestic Travel Costs

2017/18	\$	1,026,861
2016/17	\$	1,038,437
2015/16	\$	1,080,526
2014/15	\$	1,070,255

The table below outlines top 20 domestic travellers by position for 2017/18 financial year.

FY 2017/2018 Top 20 Domestic Travellers by Spend

Traveller Title	Total Spend
Anatomical Pathologist	\$ 30,057.27
Clinical Administrator	\$ 22,416.52
National Clinical Manager - Service Clinical Director	\$ 18,769.74
Senior Medical Officer	\$ 15,209.52
Immunologist	\$ 14,951.40
Programme Coordinator - Advance Care Planning	\$ 13,859.20
Programme Director - Performance Improvement	\$ 13,084.84
Forensic Pathology Technician	\$ 12,359.04
Metabolic Nurse	\$ 10,842.80
Chief Nursing Officer	\$ 10,317.02
Consultant - Pathologist	\$ 9,891.70
Technical Head	\$ 9,490.20
Chief Executive Officer	\$ 9,225.31
Senior Medical Officer	\$ 8,653.10
Medical Doctor	\$ 8,629.87
Clinical Lead	\$ 8,179.19
Clinical Coordinator	\$ 7,647.95
Metabolic Dietician	\$ 7,577.58

Physiotherapist	\$	7,165.71
Chief Health Professions Officer	\$	6,711.90

Auckland DHB is the largest provider of national and regional services across New Zealand. Regular domestic travel is required by staff to carry out service delivery roles at other DHBs.

97. What domestic airlines are used by staff and why? Provide a breakdown of spending on each airline used in 2017/18 financial year and how does this compare to each of the previous four financial years?

Response to Question 97

Domestic airlines used by the DHB and the breakdown of spend on each airline is provided in the table below. Note that due to a change in the provider for travel services, we have provided information available from the current provider for the last 3 years (since they were contracted).

Spend on Domestic Airlines	FY15/16	FY16/17	FY17/18
ABX AIR INC		\$ 242	
AIR CHATHAM	\$ 1,401	\$ 8,329	\$ 11,195
AIR NEW ZEALAND	\$ 587,325	\$ 749,721	\$ 708,631
FLY MY SKY	\$ 396	\$ 572	\$ 1,248
GREAT BARRIER AIRLINES	\$ 2,935	\$ 1,329	\$ 101
JETSTAR AIRWAYS	\$ 72,423	\$ 52,729	\$ 58,014
SOUNDS AIR	\$ 1,274	\$ 854	
QANTAS AIRWAYS	\$ 1,435		
Total Spend on domestic airlines	\$ 667,190	\$ 813,775	\$ 779,190

98. How much was spent on international travel in the 2017/18 financial year, how does this compare to each of the previous four financial years, and what proportion of operating expenditure does this represent? Please provide a list of the positions of all spenders on international travel for 2017/18, including the amount spent (broken down by travel, accommodation and other expenditure), locations travelled, reason visited and outcomes achieved. For any items of other expenditure greater than \$15,000 please provide details of what this was.

Response to Question 98

	FY 13/14	FY 14/15	FY 15/16	FY 16/17	FY 17/18
International Travel costs	\$353,534	\$491,659	\$269,504	\$326,324	\$314,671
Accommodation and Meals	\$80,768	\$78,268	\$100,856	\$176,842	\$216,173

International Travel Spend Total (\$)	\$434,302	\$569,927	\$370,360	\$503,166	\$530,844
Total DHB Operating Expenditure (\$)	\$2,004,720,619	\$2,058,416,907	\$2,046,608,977	\$2,076,152,587	\$2,192,500,675
Proportion of Total Spend %	0.02%	0.03%	0.02%	0.02%	0.02%

There is a stringent approval process in place for overseas travel with approval first required from the General Manager and/or Clinical Director and final endorsement by the Chief Executive. Most overseas travel is for staff attending international conferences and training courses to maintain clinical practice currency. The request for detail of employee positions and destinations would require manual compilation and additional resources and has not been supplied.

The figures in the table do not include the cost of overseas Continuing Medical Education (CME) travel by senior medical officers. Under the terms of their collective employment agreement, every senior doctor is entitled to reimbursement of actual and reasonable CME expenses up to \$16,000 excluding GST per calendar year. This can include the cost of overseas CME travel. CME travel is charged to a CME account code along with all other CME expenses whether incurred in New Zealand or overseas.

99. How many staff have Koru Club memberships paid for by your department, agency or organisation, and how does this compare with each of the previous four financial years? What is the policy regarding entitlement to Koru Club membership?

Response to Question 99

There are no Auckland DHB staff members with Koru Club memberships paid for by the DHB in the past four financial years.

100. How many staff had the use of vehicles paid for by your department, agency or organisation in 2016/17; what are the estimated costs; how do these numbers compare to each of the previous four financial years?

Response to Question 100

2017/18 - No staff members have had private vehicle use paid for. This is the same for the previous four financial years

101. How much was spent on internal conferences and seminars, staff retreats, offsite training, or planning and teambuilding exercises, including travel costs, and what is the purpose of each in 2017/18? How does this compare to each of the previous four financial years? For each year please include:

- a. Purpose
- b. Venue
- c. Cost (including travel and accommodation costs)
- d. Activities undertaken

Response to Question 101

The purpose of the various conferences, seminars and off-site training events was to build clinical, technical, professional, interpersonal, and leadership and management capability, and to build strong teams through team development activities.

We do not have the means to separately identify costs to the level of detail required under b, c and d. Overall training costs are provided below in our response to Question 97.

102. What are the measures used to evaluate the success or effectiveness for internal conferences or seminars?

Response to Question 102

A feedback sheet (hardcopy and electronic) at the end of events indicating satisfaction and usefulness and participants meeting specific job training and proficiency requirements. Positive changes in behaviours are also measured, and achievement of compliance and competency requirements in performance and coaching conversations. Employees are invited to complete a full survey on employment every 2 years, including about training and development.

103. How much was spent on staff training in 2017/18; and what percentage of the vote does the amount represent? How does this compare to each of the previous four financial years?

Response to Question 103

	FY 13/14	FY 14/15	FY 15/16	FY 16/17	FY 17/18
International Travel costs	\$353,534	\$491,659	\$269,504	\$326,324	\$314,671
Accommodation and Meals	\$80,768	\$78,268	\$100,856	\$176,842	\$216,173
International Travel Spend Total (\$)	\$434,302	\$569,927	\$370,360	\$503,166	\$530,844
Total DHB Operating Expenditure (\$)	\$2,004,720,619	\$2,058,416,907	\$2,046,608,977	\$2,076,152,587	\$2,192,500,675
Proportion of Total Spend %	0.02%	0.03%	0.02%	0.02%	0.02%

Please see table below:

	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018
Staff training costs \$	19,069,000	18,472,000	15,733,000	21,361,000	20,878,000	23,347,057
Total DHB Revenue \$	1,967,697,071	2,004,982,409	2,058,769,934	2,049,479,508	2,079,314,259	2,193,512,676
Training as % of DHB Revenue	0.97%	0.92%	0.76%	1.04%	1.00%	1.06%

104. What specific activities or events were conducted that contributed towards staff morale in the last financial year?

Response to Question 104

The following activities have been undertaken:

Recognition Programmes:

- Health Excellence Awards
- Nursing and Midwifery Awards
- Allied Health, Scientific and Technical Awards
- Monthly Local Heroes awards
- Long Service Awards
- Values Thank You cards for all employees
- Recognition cards from CEO
- Team celebrations and shared morning teas

Communication / Engagement / Visible Leadership

- People Strategy focused on our people being a happy, healthy and high-performance community
- Nova magazine
- Regular CEO Blog
- Team Talk Blog (ELT members)
- Our News
- Pink Shirt Day
- Staying Connected – CEO forum
- Union Collaboration forums
- Employee Engagement Survey action plans
- Patient Experience Feedback – published monthly
- CEO visits to workspaces
- Regular ward rounds
- Bi-monthly Navigate – Kai Arahi orientation sessions to welcome new employees

- Regular Executive presence at key events (e.g. Navigate – Kai Arahi; Leadership Development celebration events)

Diversity Celebrations

- Christmas celebrations and activities
- Celebrating Maori Language Week
- Pasifika Week
- Transgender week of awareness
- Accessibility Tick activities
- Rainbow tick / pride parade activities

Employee Wellbeing

- Yoga classes
- Mindfulness training
- Resilience training
- Wellbeing Week
- Healthy workplace strategy
- Organisational Values workshops
- Speak Up Programme with Speak up Supporters
- Subsidised gym memberships
- Employee Assistance Programme (EAP) all employees entitled to x3 free sessions
- Vaccinations: free influenza vaccination for all staff, others dependent on clinical risk
- Cervical screening visit sites
- Staff cafeteria with healthy food options
- Chaplaincy services
- Health & Safety Representatives
- Smoke free environment and smoking cessation support
- Bike to work days
- Schwarz Manaakitia Rounds
- Subsidised health insurance
- Onsite Marae facilities
- Kahui Hononga Maori Workforce Huis

Training & Development

- Personal and professional development programmes (individual and cohort)
- Leadership Development Programmes
- Literacy programmes - financial and digital
- Lunchtime seminars
- Development funding for individuals (trusts and education allowance)
- Research
- Clinical Skills Centre

Additional Staff Perks

- Work Perks (staff discount buying programme)
- On-site staff parking
- Crèche at both main sites

Low Paid Worker Strategy

- To Thrive programme of education, support and benefits

105. How much was spent on pay television subscriptions (such as SKY and Netflix) in the last financial year and for how many subscriptions? How much was spent in each of the previous four financial years and how much has been budgeted for the latest financial year?

Response to Question 105

The DHB does not fund pay television and has not spent anything on pay television over the previous four financial year.

106. What is the total amount spent, if any, on speaker's fees and/or speaker honorariums for year of the last seven financial years by event, event date, speaker and amount received?

Response to Question 106

This information is not readily available from our financial system. Staff recollect the following only for

FY2016/17

\$7000 USD (including x 100 books) – Susan David

NZ \$1,300 invoice for x 50 books – Angela Atkins

Cost of gifts for guest speakers \$20 (Winsborough)

and there has been no activity that staff can recall for 2017/18.

107. Does your department, agency or organisation pay travel and/or accommodation costs for guest speakers; if so what was the total amount of travel and/or accommodation costs paid over the last seven financial years by speaker and event spoken at?

Response to Question 107

No expenditure in FY2017/2018

108. What special units, task forces or reviews have been set up; and what particular issue or issues are they providing advice or analysis on? How many people are in any such units or reviews, and from what other government departments or outside organisations, if any, are they drawn? What is the total cost of this work?

Response to Question 108

Special reviews were undertaken as follows:

Independent Expert Panel for long-term Auckland DHB PICU patient

An independent expert panel was established to review plans for transitioning a long-term patient from the paediatric intensive care unit (PICU) of Starship Children's Hospital to home.

The patient has been in PICU since her admission in her infancy and the agreed clinical priority between clinicians and parents is to progress her towards home care. Due to the complexity of this case, the independent review of the transition plans for the patient provide assurance that the plans meet the needs of the patient and that they are implemented appropriately.

Specific responsibilities of the panel are as follows:

- Reviewing the transition plan before it is implemented
- Listening to the views of the parents and clinicians
- Providing further and final assurance to the Chair of Auckland DHB that the plan is in line with best practice delivered in other publically funded healthcare systems in Australia and the United Kingdom
- Provide further and final assurance to the Chair of Auckland DHB that the plan is best for the patient.

In 2017/18 the total cost of this work was \$31,295.07

Capacity planning for Auckland DHB heart, lung and liver transplantation services

Experts from Ernst & Young were retained to undertake a review of the workforce and physical capacity required for Auckland DHB's heart, lung and liver transplantation services over the medium term.

The estimations of capacity needs and the likely demand for transplantation services have informed detailed operational planning which will enable Auckland DHB to manage increasing transplant volume as well as general increases in acute demand. This work has also informed consideration of future models of care for heart, lung and liver transplant services and formulation of an appropriate response to improve equity of access to transplant services.

The total cost of this work was \$125,312.72

109. What actions, if any, have been taken to improve the seismic safety of buildings, offices, and workplaces; or the seismic resilience of key infrastructure? What is the total cost of this work?

Response to Question 109

Over the last 20 years Auckland DHB has implemented a significant seismic risk management programme across its major hospital sites. During that time 6 seismic risk buildings have been demolished, 2 buildings have been vacated and 3 buildings have been seismically strengthened. The works to date have focused on the structural capacity of buildings - i.e. the percentage of New Building Standard achieved for existing Auckland DHB buildings. Only a small number of earthquake prone buildings remain none of which contain patient services. In more recent years Auckland DHB has turned its focus to assess the seismic restraint of non-structural building elements. As with the structural programme this is expected to be an on-going exercise with phasing determined by the assessed level of risk and available resources. The first step undertaken in 2016/17 was a preliminary review of the seismic restraint of critical infrastructure assets (e.g. boilers, chillers, transformers etc.) distributed across the main buildings at the Auckland City Hospital site. The review found 40% of these assets to have poor restraint. Steps to improve the seismic restraint of these critical assets are planned as part of the ADHB Facilities Infrastructure Remediation Programme (FIRP). In July 2018 the first tranche of this major investment programme was approved by the Crown at a total cost of \$305million. This includes \$18.9million over the next three years for a seismic upgrade of building

services assets on the Auckland City Hospital site. Work is now underway to plan and tender these upgrades.

110. What actions, if any, have been taken to lower greenhouse gas emissions; and how does the level of greenhouse gas emissions in 2017/18 compare to previous years? What is the total cost of this work?

Response to Question 110

The DHB vision is: Healthy communities, world-class healthcare, achieved together 'Kia kotahi te Oranga mo te iti me te Rahi o Te Ao'. Our organisation has a critical role in the community to reduce the impact on the environment, disruption and harm to the communities we serve today and in the future.

Auckland DHB is committed to reducing its carbon footprint through energy efficiencies, waste minimisation strategies, innovation, technology, education, and a change in culture that embraces sustainable practice. We are setting an ambitious goal of being carbon neutral by 2050 with the vision "to meet the needs of today without adversely impacting on the needs of the future generation". We believe that this is our social responsibility within the health sector to raise awareness of the health effects of climate change and the potential health co-benefits of low carbon pathways.

Our core values align with reducing carbon emissions and social inequities that are regarded as precursors to poverty and poor health outcomes. Hence, we are consciously taking a social stand for the population we serve to reduce the environmental impact from our services. Our sustainable practice is far-reaching underpinned by the Sustainability Strategy and operational framework to support wider stakeholder engagement across the organisation to bring about change in culture and practice. The integration within our organisation is being advanced by the executive leadership team who have focussed on eight key functional areas which are inter-dependant and represent the building blocks for sustainability and a low carbon organisation.

Carbon Emissions Reduction Programme

We identified all the key elements that represent our carbon footprint and other factors to help with overall sustainable strategy with key work-streams for example;

1. Executive Leadership

Our Executive Leadership team is strongly committed to the zero carbon target by 2050 and as a leading health sector provider that this long-term goal should bring the whole organisation and our stakeholders along on the journey and that;

- The sustainability programme is tightly integrated with the DHB's broader organisational strategy in order to present a coherent and prioritised programme of work.
- Extend the scope of focus from carbon and climate to embrace the broader United Nations sustainability agenda.
- The principles align with Te Runanga o [Ngāti Whātua](#) in exercising kaitiakitanga responsibilities.
- The NHS UK sustainability framework is adopted to provide mechanism for reporting the financial, environmental and social impact of health services.

A Sustainability Steering Group has been established to oversee the development of the Sustainability Strategy, align Strategy to the UN Sustainable Development Goals and provide advocacy and leadership for sustainability work across the Auckland DHB.

2. Clinical Leadership

As a major tertiary and secondary health service provider, senior clinicians are committed to the organisation's sustainability strategy. They provide expertise on the health benefits on lower carbon approaches to increase health equity in line with the WHO Sustainability Development Goals.

The Auckland Regional Public Health Service senior medical officer was the key clinical lead in writing the DHBs Submission on Low-emissions Economy – Issues Paper and the Auckland Council NIWA project and this was on behalf of the Northern Region DHBs.

3. Culture Learning & Development

We continue to host monthly sustainability forums for staff and external stakeholders to draw on the experience from highly respected advocates and subject matter experts to discuss issues, exchange ideas and share learning to build resilience and knowledge within the organisation.

Using internal communications platforms we are building green teams (theatres, wards, procurement and energy) to advance a collective culture for change. Our aim is to promote sustainability, build strong networks, provide training and empower staff to lead low carbon initiatives particularly in waste recycling.

Exhibitions – we regularly promote sustainability through exhibitions/stands for example Earth Day, Recycle Week. We also provide learning events using the Auckland Council initiatives for example; Wastewise, Live Lightly and Wai Auckland. These are held in collaboration with external stakeholders including Local council, suppliers and waste companies to reduce waste and increase our recycling initiatives.

4. Energy Efficiency

In 2017 Auckland DHB in collaboration with the Electricity Efficiency Conservation

Authority (EECA), created a new vision, Energy 50/50 with the aim of reducing energy use by 50% and producing 50% of the site's energy requirements through renewable energy by 2030 thereby improving the sites resilience and staff working environment.

We have 17 energy management projects either been completed, underway or being planned. To date the EECA/DHB collaboration is progressing to plan using innovation and technology to existing buildings including; lift upgrades, additional metering, energy management & monitoring electronic dashboard, PC sleep applications. In the last 12 months, 2.8 million kWh of energy has been saved. This is equivalent to the annual consumption of 395 average NZ households

In 2018 we were commended by the NZI Sustainable Business Network as well as the Energy Efficiency and Conservation Authority (EECA) for the energy work.

5. Building & infrastructure

The DHB supports green and healthy re-generative hospital design, construction and refurbishment to improve the internal environment for both staff and patients.

Initial design considerations are being applied to achieve green building certification with a number of upcoming capital projects for example; Economic retrofitting / replacing of existing plant and equipment with green/energy efficient items, the new central plant building Grafton; the new Cancer Centre building Grafton. A construction waste pilot is also being undertaken to better understand the type and volume of construction sent to landfill.

6. Procurement

We are working with our procurement agency HealthAlliance to develop a Sustainable Procurement framework that will consider product life-cycles and criteria for ethical use of resources, certified standards and environmental impact from the disposal of end of life products and packaging.

Recent tenders for sustainable product include paper drinking cups, biodegradable drug trays, rubbish bags and paper pill cups.

7. Waste Management

In 2015 we launched our waste minimisation programme with primary aim being waste diversion from landfill and recycling to drive the circular economy.

Supplier product responsibility is also being applied where we work with key suppliers to promote the circular economy principles of end of life product for repurposing.

A summary of our recycling programme includes;

- Office waste: recycling tri-bins for public areas and staff kitchens and 7,000 office-desk cubes.
- Clinical waste recycling; PVC fluid bags, single use theatre instruments, glass vials, aluminium medical bottles, drug trays, single use scissors, anaesthetic aluminium bottles,
- General waste; soft plastic packaging, hard plastic, glass, aluminium, cardboard, office paper
- Inorganic waste, e-waste, office equipment, medical equipment
- Food waste pilot
- Water coolers and water stations in key staff/public areas to introduce healthy drinking options and reduce the level of single use plastic bottles.
- Working food and beverage retailers and patient meal provider to eliminate single use plastic packaging by 2025.
- Community engagement: We also promote safe disposal of unwanted medicine at home. This is a regional initiative for patients to dispose of unwanted medicine at their local pharmacy.

8. Networks

Sustainable Business Network

Membership of the SBN provides a valuable platform for networking, shared learning and exchange of ideas. The membership has motivated staff to develop and implement initiatives for the annual SBN awards. In 2017 we received 2 finalist nominations and in 2018 we received 4 nominations including Going Circular, Efficiency Champion.

Green Global Healthy Hospitals (International)

The GGHH is a global network of hospitals which provides access to international case studies and links to other organisations who are also working to reduce emissions and create healthy hospital environments.

In 2017 our emissions was recognised with three awards; Silver - GHG Reduction (Energy) Silver - GHG Reduction (Non-Energy) and Silver - Climate Change Leadership

Auckland Council: Auckland's Climate Action Plan [ACAP]

The DHB has been a key stakeholder in discussions for establishing the Auckland Council-led programme focussed on Zero Carbon Bill and climate change action.

SDG Summit 2019 Stakeholder Group

The DHB is involved in this event convened by UOA&AUT. The SDG summit will be held in Auckland in 2019 with a key message being "an accelerated action, together".

The Summit vision is that by 2030, NZ to be using the SDGs to transition to a sustainable future in accordance with the principles of sustainable development.

Auckland Regional Public Health Service in the community:

ADHB is working is linking into the community through initiatives that will address good health and well-being and protecting the environment. For example;

Healthy Auckland Together (HAT)

HAT is a coalition of 21 organisations representing local government, mana whenua, health agencies, NGOs, university and consumer interest groups. Its vision is of "a social and physical environment that supports people living in Auckland to eat well, live physically active lives and maintain a healthy body weight within their communities". It has a 5 year action plan to improve nutrition, increase physical activity and reduce obesity.

Wai Auckland Promotes tap water; reduce consumption of sugary drinks to improve health outcomes in children. This initiative aligns with the water cooler initiative at the hospital site.

How does the level of greenhouse gas emissions in 2017/18 compare to previous years

In 2015 we initially set an emissions reduction target of 2% per annum or 20% by 2025. We have exceeded this target with a 28% reduction against the 2015 baseline of 10,280.21 tCO2e reductions.

The emissions reduction against the baseline year (2015) is attributed to Natural Gas (53%), Electricity (18) and air travel (35%)

Carbon Emissions	2015 (baseline)	2016	2017	2018
t CO2e	36,892	32,498	30,252	26,611

Total cost of this work

The 17/18 financial year cost for environmental/sustainability initiatives;

- CEMARS programme \$30k
- Membership to networks \$5k
- The cost of energy initiatives to date are \$207k
- Initiatives built into budgets; waste management/recycling, educational forums, promotions, procurement initiatives are all managed within existing resources and operating budgets.

111. What actions, if any, have been taken to improve the gender pay gap; and how does the gender pay gap in 2017/18 compare to previous years? What is the total cost of this work?

Response to Question 111

Gender pay gaps are minimal because more than 95% of our employees are covered by Collective Agreements. Rates of pay are set according to post qualification experience and/or time in a role. We do not have an active programme to monitor or improve any remaining gender pay gap.

Individuals employed on individual employment agreements are paid market rates and gender pay analysis is reviewed by the Executive Leadership Team (ELT) as part of the annual salary review process.

112. What specific work, if any, has the department, agency or organisation undertaken in relation to the Government's 100 day plan? Has this required the employment of additional staff, contractors or consultants; if so, for what purpose? What is the total or budgeted cost for undertaking this work?

Response to Question 112

Auckland District Health Board (DHB) has undertaken work that complements the following three goals in the Government's 100 day plan. This work is part of planned activity and has not required the employment of additional staff contractors and consultants. As this work has been developed within existing resources there are no specific costs that can be reported.

Set up a ministerial inquiry into mental health crisis.

Work was undertaken on the Auckland DHB's Mental Health and Addictions strategic programme which aims to support development of a coordinated suite of mental health and addiction services to address pressing needs for our population. It is also anticipated that this programme will ensure that people will know where to go for assistance with their mental health needs and that the DHB will deliver a sustainable specialist mental health and addictions service that will receive appropriate referrals from GPs and other primary care providers. The programme specifically focuses on early years (e.g., maternal and infant health services), youth and peer services, first point of contact (e.g., developing health pathways and whānau access pathways), acute alternatives (e.g., establishing peer support workers), zero coercion (leveraging existing natural supports including family/whānau, peer and non-peer youth and adults), equally well (addressing inequity particularly for people with severe mental health, Maori and Pacific people) and zero suicide.

Work was also undertaken on developing our Facilities Infrastructure Remediation Programme. Whilst this Programme does not focus solely on mental health, it will ensure that the capacity and configuration of our infrastructure is sufficient to support the service evolution necessary to meet the growing demand on mental health services.

We have also continued development of our Tāmaki Mental Health & Wellbeing Initiative (www.tamakiwellbeing.org.nz). The Initiative was launched in 2013 to help create a new experience of mental health and wellbeing support in Tāmaki in response to a directly expressed need from the community, and an acknowledgement that traditional ways of working needed to change. We are working together with the local community, social agencies and local providers with the focus being to put the design of support in the hands of those that will use and provide it. During the 16/17 financial year we launched a new support service Awhi Ora: Supporting Wellbeing service off the back of the Initiative. Awhi Ora is funded from existing community mental health support funding.

Increase the minimum wage to \$16.50 an hour, to take effect from 1 April 2018, and introduce legislation to improve fairness in the workplace.

Auckland DHB employs approximately 360 permanent employees paid an hourly rate below the NZ Government's minimum wage target of \$20.00 by 2021. This represents 4% of our permanent workforce. 71% of these lower income employees are working as a Cleaner or Orderly.

As part of our People Strategy 2016-2019, Auckland DHB has committed to supporting this employee group to maximise their income through access to job specific training, financial literacy education and an understanding of supplementary income opportunities. The latter includes partnership with Ministry of Social Development to ensure good communication of government subsidies and support.

The THRIVE programme has been developed to deliver sustainable (low cost, high impact) programmes and benefits (an employee value proposition) for our lower income employees that:

- Demonstrate that we value our employees and are responsive as an employer to their feedback
- Facilitate a workplace culture of trust and support
- Encourage and improve employee health and wellness
- Support employees financially in times of personal hardship
- Enable employees to make informed financial decisions that will positively impact them and their families
- Provide learning opportunities and a career path for those employees that want to develop their skills and move to other roles within the Auckland DHB.

A significant investment in this programme is time, including the commitment from Human Resources to implement and facilitate initiatives, and from our services to release employees to attend programmes during (or between) shifts.

In keeping with our People Strategy's public promise to provide "Transparency and fairness to ensure we can all live our values and commitments", a role is currently being recruited to operationalise support mechanisms and initiatives for the following four ADHB employee groups:

- those with disabilities
- those with mental health needs (including measures for supporting those who develop mental health needs)
- our lower income employees; and
- young people in our community who may or may not be work ready

The role will also extend the THRIVE programme to these employee groups as appropriate and relevant.

To enable delivery of our promise to all employees "To champion and support your physical and mental wellbeing, just as you do for those we serve", we have appointed an Organisation Development Practice Leader specifically holding the Wellbeing portfolio. This is a new role which will start with a focus on burnout and kindness at work for this calendar year.

Our aim is for everyone at Auckland DHB to experience the environment and opportunities to do their life's best work.

Set the zero carbon emissions goal and begin setting up an independent Climate Commission.

Auckland DHB has been certified under the Carbon Emissions Management and Reduction Scheme (CEMARS) since 2015. Under this Scheme, the DHB is committed to reducing annual emissions by a minimum of 2% per annum to achieve a total of 20% reduction by year 2025. We have also established carbon monitoring around our two major sites, Grafton and Greenlane.

By engaging in the CEMARS programme, we have been able to shape our carbon reduction strategy. This is being advanced through leadership, including sustainability champions in our services to lead waste initiatives, empowerment of staff, implementing sustainable projects, introducing innovative products and systems, and celebrating successes.

When Auckland DHB commenced the CEMARS programme, a conservative emissions reduction of 2% per annum and 20% by year 2025 was set. Our CEMARS certification for 2016/17 shows that our emissions are 21% lower than the 2015 base year. This reduction was mainly attributable to a reduction in natural gas by 12 per cent, air travel down 30%, electricity use down 25% and waste to landfill down 11%.

These savings are equivalent to:

- Driving from Auckland to Wellington in a medium sized petro engine car 56,868 times.
- Burning 3,637,345kg of coal.
- The volume of 36,546 Olympic sized swimming pools.
- 1,413 return economy flights from Auckland to London.

We have also committed to formalising a comprehensive sustainability strategy in the short term.

113. What proportion of Maori compared to Non Maori, with a diagnosed and coded cardiovascular related disease for which best practice such as BPAC recommends a lipid lowerer, were prescribed a lipid lowerer for more than 6 months in the past financial year?

Response to Question 113

Lipid lowering cardiovascular medications are routinely reported by ethnicity within the indicator of triple therapy (namely anti-platelet, blood pressure medications and statins to lower lipids).

Auckland DHB proportion of enrolled patients with a prior CVD event dispensed triple therapy pharmaceuticals

Ethnicity	12 months to March 2018
Maori	50.9%
Non-Maori	51.1%

Source: Northern Region Cardiac Network: Cardiac KPI Report

114. Please attach the latest Maori Health plan.

Response to Question 114

The Ministry of Health did not require a Maori Health Plan to be provided, however Auckland DHB continued to develop and action a joint Maori Health Plan with Waitemata DHB.

Link to: [2017/18 Māori Health Plan](#)

115. Given the health of Māori in your DHB in the past year, If the DHB had been given \$1M per year of new untagged funding, for 4 years, to address highest incident local ASH differences between Māori and non-Māori in ambulatory sensitive hospitalization rates (ASH) per 100,000 for the age groups 0-4 and 45-64 years, what policy or program would you have implemented?

Response to Question 115

0 to 4 year olds – Top three conditions with the greatest difference in rates (Māori vs. non-Māori/non-Pacific) – 12 months to June 2018

Condition	Māori Rate	Non-Māori/non-Pacific* rate	Rate difference (absolute)
Asthma/Pneumonia/lower respiratory tract infection (LRTI)	3740	2558	1182
Cellulitis	891	409	482
Pneumonia	687	394	293

*non-Māori/non-Pacific includes Asian and Other ethnicities

45 to 64 year olds – Top three conditions with the greatest difference in rates (Māori vs. non-Māori/non-Pacific) – 12 months to June 2018

Condition	Māori Rate	Non-Māori/non-Pacific* rate	Rate difference (absolute)
COPD	808	89	719
Angina and chest pain	1366	786	580
Cellulitis	772	308	463

*non-Māori/non-Pacific includes Asian and Other ethnicities

ASH for 0-4 year olds is national System level Measure (SLM) and therefore included in the metro Auckland SLM and monitored by ethnicity (Māori and non-Māori). The SLM Improvement Plan details actions aimed at preventing respiratory admissions and oral health admissions that are leading causes of ASH coded admissions for Māori. The focus for respiratory admissions is on

primary healthcare and Well Child Tamariki Ora (WCTO) services enrolment, child and maternal influenza immunisation, maternal pertussis immunisation, healthy housing and work to address wider social determinants of health, and maternal smoking cessation initiatives. The actions within the SLM Improvement Plan were developed through an extensive consultation process with secondary care services and specialists, our primary healthcare partners and clinicians working at the flax-roots, Māori health providers and leaders, and Māori communities through our Treaty Partners – Ngāti Whātua and Waipareira. Any additional funding would be invested into supporting these existing pieces of work within our SLM Improvement Plan.

For 45 – 64 year old Māori ASH rates is a target within our Māori Health Plan and a contributory measure in the metro-Auckland SLM plan for both the Amenable Mortality SLM and the Acute Bed Days SLM. The SLM Improvement Plan ASH 45-64 year old primary care focus is on primary and secondary prevention of cardiovascular disease (CVD) and smoking cessation and includes Māori specific targets. In addition, there is a focus on increased utilisation of Primary Options for Acute Care for ASH conditions for Maori, particularly for COPD and cellulitis. Increasing primary healthcare enrolment by data matching between PHOs and Māori health providers is underway currently under the Maori Health Pipeline. The Māori Health Pipeline is an initiative started in 2017/18 led by the Māori Health Gain Team and Health Gain Teams (Planning, Funding and Outcomes) to accelerate specific projects that aim to improve Māori Health and close the life expectancy gap. Any additional funding would be invested into supporting existing pieces of work outlined in the Maori Health Plan, the SLM Improvement Plan or the Maori Health Pipeline

116. Given the health of Maori in your DHB in the past year, If the DHB had been given \$1M per year of new untagged funding, for 4 years, to improve breast feeding rates in Maori, what policy or program would you have implemented ?

Response to Question 116

Increasing breastfeeding rates amongst Māori is a target for our DHB featuring in both our Māori Health Plans and Annual Plans. Our approach, guided by support from the sector and an analysis of data and research, has been to engage with and provide targeted breastfeeding support to pregnant and new Māori mothers. Our Healthy Babies Healthy Futures programme engages with pregnant and new mothers by providing advice and health education directly to mothers (and their partners). Auckland DHB both provide marae-based wānanga to pregnant Māori mothers with a particular focus on SUDI, with key breastfeeding messages a part of the education provided.

With increased funding, we would extend the scope of, and integrate, this work to create a holistic and targeted model of care for hapu wahine and whānau aimed at engaging mothers intensively until their pēpi is at least 6 months old. Additional funding to develop this approach would importantly include wraparound support with input from social workers to supported resolution of other barriers to access to high quality care and a healthy home environment for mama and pepi.

We would utilise existing resources and fill gaps across the maternity and child health sector, and extend work into other social support sectors noting that financial pressure to return to work is a barrier for maintaining breastfeeding. In particular, support would include training (clinical and cultural) and supporting a workforce of lactation experts to work intensively with Māori whānau, while also integrating care amongst a range of providers to support the alleviation of other pressures vulnerable whānau may be experiencing. Lactation support would form a single strand of a broader strength-based model of care targeted at Māori women/carers. This would include all-of-whānau enrolment with health services, connecting with other mothers/support groups, nutrition education, information about pēpi development and growth, immunisation support, smoking cessation, safe

sleeping, mental health and wellbeing support, and care coordination/navigation for vulnerable whānau.

Increased funding would also support an extension of this model to include socio-economic support, primarily addressing financial pressure to return to work so that mothers can breastfeed and be with their pēpi for longer, or engaging employers to support new mothers breastfeeding, privately breast pumping and storing collected milk, or flexible working arrangements.

117. Given the health of Māori in your DHB in the past year, If the DHB had been given \$1M per year of new untagged funding, for 4 years, to improve cervical screening rates in Māori, what policy or program would you have implemented?

Response to Question 117

Human papilloma virus (HPV) self-sampling offers a potential intervention to address the long standing inequities in cervical screening coverage. In order to provide policy relevant advice on this intervention Auckland DHB has invested in the completion of a HPV self-sampling feasibility study for Maori women, and is now supporting the larger clinical trial of invitation methods including Maori, Pacific and Asian women. Self-sampling is a promising intervention that could provide a step-change in coverage, therefore clearly establishing evidence on how unscreened and underscreened priority women, particularly Maori women, respond to this technology and how it can be optimised is important and further investment is warranted.

Further investment could also be beneficial to strengthen the support focused infrastructure to guide women and their whānau through screening education, improving reminder approaches, and more intensive care coordination and outreach for those currently missing out, including HPV self-sampling and home visits. An integrated screening infrastructure with other screening programmes could improve efficiency and optimise the skilled workforce for coordination and outreach activities supported by accessible data.

We have developed a Māori pipeline of initiatives, projects and programmes of work specifically targeted at achieving Māori health equity. The current Maori pipeline includes a project for women with a history of high grade cervical abnormalities detected via the cervical screening programme, but incompletely followed up and therefore at clinical risk. The project will identify women and offer a tailored and intensive support to follow up clinical service. Investment in a model as described above would support projects such as this.

118. Given the health of Māori in your DHB in the past year, If the DHB had been given \$1M per year of new untagged funding, for 4 years, to improve breast screening rates in Māori, what policy or program would you have implemented?

Response to Question 118

We have developed a Māori pipeline of initiatives, projects and programmes of work specifically targeted at achieving Māori health equity. In the pipeline we have a breast screening project called the '500 Maori women campaign' which is a Northern Region project (led by Auckland DHB and Waitemata DHB) designed to offer service to those women currently missing out, and achieve screening approximately 500 additional Maori women to achieve the ethnic-specific coverage target. This project is a demonstration project to provide learning for a national datamatch, matching primary care enrolment and BreastScreen Aotearoa (BSA) data to identify women who are unscreened or underscreened and offer them service through their local BSA lead provider.

For Auckland DHB, which has a private Lead Provider of breast screening services rather than a DHB provider, the '500 Maori women campaign' includes an additional datamatch with hospital data to identify women who have touched our services and are unscreened or underscreened and offer them screening. This will help address the issue of women who are not enrolled in a PHO. The demonstration project facilitates shared learnings with the region's three lead providers and policy relevant advice for the development of a breast screening population register.

Further investment could support additional resource for contacting women for offer of service in both projects to accelerate their completion and establish a routine datamatch process (regionally or nationally).

119. What percentage of pregnant Māori women are smoke free at two weeks postnatal, and compare these rates for Māori and Non-Māori listed by year over the past 4 years?

Response to Question 119

The latest available trend data for the indicator requested is provided in the table below, however it is only available to 2015.

Women smokefree at 2 weeks post-partum, Auckland DHB, 2011-2015

Year	Māori	Non-Māori / Non-Pacific*
2012	88.7%	99.4%
2013	87.7%	99.3%
2014	87.9%	99.3%
2015	86.8%	99.5%

Source: National Maternity Collection Data Set (Ministry of Health)

* Note: Comparator population non-Māori/non-Pacific includes Asian and Other ethnicities

Whilst maternity data are not yet available for 2016-2018, there are 2018 data from Well Child Tamariki Ora (WCTO) providers on the percentage of babies living in a smokefree home at 6 weeks of age, and this is a System Level Measure (SLM) Improvement Plan indicator (see response below). The data in the table below provide additional evidence of the burden of tobacco smoking on Māori pepi, particularly those living in areas of higher socio-economic deprivation.

Percentage of babies living in a smokefree home at 6 weeks of age, Auckland DHB, Jan-Jun 2018

NZ Deprivation Quintile	Māori	Non-Māori & Non-Pacific
Q1 (low deprivation)	71.4%	73.8%
Q2	66.7%	77.8%
Q3	45.3%	68.4%
Q4	42.6%	75.6%
Q5 (high deprivation)	28.3%	70.4%

Source: Well Child Tamariki Ora Data (Ministry of Health)

* Note: Comparator population non-Māori/non-Pacific includes Asian and Other ethnicities

120. Given the health of Māori in your DHB in the past year, If the DHB had been given \$1M per year of new untagged funding, for 4 years, to improve postnatal screening cessation in Māori, what policy or program would you have implemented?

Response to Question 120

In this response we assume that the question refers to postnatal *smoking* cessation rather than postnatal screening cessation.

Babies living in smokefree homes is a System Level Measure (SLM) indicator with activities outlined in the metro-Auckland SLM Improvement Plan. In order to minimise the impact of tobacco smoke on Māori pepi, cessation activities should focus on engagement during pregnancy and not solely in the post-natal period. In 2018 Auckland DHB, with Waitemata DHB, funded an incentivised maternal and whānau (those living with a pregnant woman) smoking cessation pilot that has Māori whānau as a priority population. The current focus of activity is increasing referrals to this programme from primary care, lead maternity carers, Well Child Tamariki Ora (WCTO) providers and Māori providers. Increased investment would allow the expansion of incentives in this programme and the expansion to all relevant whānau.

Further increased investment into smoking cessation as a well-recognised critical area of Māori health would go into extending services and interventions for Māori. This could include whole of population roll out of our smoking incentives programme with a focus primarily on Māori wahine and cover all ages from youth (prevention) to older women who smoke. For the latter, intensive therapy and relapse planning provided by qualified addiction counsellors who are also culturally competent would form the core of a service focused on supporting smokers to quit – no matter how long it takes. Additional support could include addressing the social determinants of health which place Māori youth and women at an increased risk of initiating smoking and impact on the success of quit attempts.

121. Given the health of Māori in your DHB in the past year, If the DHB had been given \$1M per year of new untagged funding, for 4 years, to improve Māori infant immunisation rates at 8 months of age especially, what policy or program would you have implemented?

Response to Question 121

Timely infant immunisation is important, however prevention of whooping cough in very young infants is best achieved by immunisation during pregnancy which is >90% effective in preventing hospital admission in infants under 3 months of age.

Whilst antenatal pertussis immunisation coverage has improved for Auckland DHB since 2016, there remains considerable inequity in coverage (see table below). Improving antenatal immunisation, both for pertussis and influenza, is an activity in the metro-Auckland SLM Improvement Plan and contributes to improving the Ambulatory Sensitive Hospital Admissions SLM for 0-4 year olds.

Ethnic-specific antenatal pertussis immunisation coverage for women who delivered in the 12 months to June 2018, Auckland DHB

Maori	Pacific	Asian	European/Other
29.8%	30.3%	56.3%	57.9%

Therefore, whilst a focus on 8 month immunisation rates is appropriate, additional investment would also go towards improving antenatal immunisation coverage. There is evidence that

improving antenatal immunisation also results in improvements in childhood immunisation coverage providing an additional benefit for this activity.

If additional investment was required to be targeted to the 8-month immunisation milestone then investment would extend the highly trained community based outreach services, with a strong Māori centred approach and understanding of local communities, to find and engage vulnerable whānau, and successfully immunise their tamariki. The extended service would consist of clinical and social/cultural roles working together to achieve successful immunisation outcomes (while also supporting whānau who require additional care through service coordination and referrals). The current infrastructure supporting child immunisation would be supported to integrate Lead Maternity Carer (LMC), primary health care, Well Child Tamariki Ora (WCTO), education, and social support services information into a single system accessible by this intensive Māori outreach service. Ideally this type of service would not be limited to immunisation and could support whānau and tamariki from before birth to 5 years of age. An enhanced outreach service would include Saturday and after hours home visiting protocols for tamariki Maori.

122. Given the health of Māori in your DHB in the past year, If the DHB had been given \$1M per year of new untagged funding, for 4 years, to improve rheumatic fever hospitalization rates, what policy or program would you have implemented?

Response to Question 122

Auckland DHB has a Rheumatic Fever (RHF) Prevention Programme in place which focuses on both primary and secondary rheumatic fever prevention and treatment for Māori. Based on the major risk factors identified in the Rheumatic Fever Case Control Study, new activities should focus on prevention of Acute Rheumatic Fever (ARF) in children and young people with a family history of ARF/rheumatic heart disease both by providing better access to regular throat swabbing in settings across the health sector, and by proving support through our Kainga Ora – Healthy Housing Initiative (HHI) to improve housing and address social issues for the whānau.

Numerous housing conditions have been identified as significant risk factors for ARF including structural and functional housing, cold and damp, bed sharing and hot bedding, and fuel poverty. Therefore additional investment in Kainga Ora – Healthy Housing Initiative should include increased access to resources to relieve the burden of these risk factors for whānau who have a family history of rheumatic fever.

In addition, funds could be used to pilot an incentives programme to support youth with rheumatic fever and/or rheumatic heart disease to receive secondary prophylaxis to prevent recurrence of acute rheumatic fever. Recurrences of ARF significantly increase the risk for heart valve damage, heart failure, and premature death.

School-based throat swabbing has been a core part of the national Rheumatic Fever Prevention Programme. With Waitemata DHB, Auckland DHB has carefully assessed the local rates of rheumatic fever and location of cases across the DHB boundaries in order to consider options to fund a school-based throat swabbing programme. An appropriately sized school based programme would cost more than \$2M per year and the current evidence base demonstrates that such an approach is not cost effective in Auckland DHB. Even if this level of investment were available we would still prioritise the two interventions described above over a school-based throat swabbing programme due to the nature of disease in our area and the evidence from the Rheumatic Fever Case Control Study.

123. Given the health of Māori in your DHB in the past year, If the DHB had been given \$1M per year of new untagged funding, for 4 years, to improve Māori pre-school children enrolment in the community oral health service, what policy or program would you have implemented?

Response to Question 123

The metro-Auckland Auckland Preschool Oral Health Plan has an explicit commitment to reduce inequity in oral health access and outcomes for Māori. Additional funding would go towards supporting and extending work already planned and underway as outlined in the Plan. Specifically, work would focus on automatic enrolment for Maori pepi that move into the region and supported follow-up with oral health services for Māori pēpi from two to five years of age or while engaged with other services – primary healthcare, Well Child Tamariki Ora (WCTO) providers, and resourcing providers already engaging with Māori whānau to identify tamariki not enrolled and enrol them on the spot. We have supported data matching between Māori health providers and oral health services to identify shared list of eligible yet not enrolled tamariki at six months of age, under our Maori Immunisation Reference Group (which also includes oral health as a priority), and collectively set about finding and enrolling these tamariki. This has included work with kohanga reo and kura. This has proved successful and we would continue to resource these initiatives, and automate processes for data matching with any additional funding.

124. Given the health of Māori in your DHB in the past year, If the DHB had been given \$1M per year of new untagged funding, for 4 years, to improve Māori served section 29 community treatment orders or equivalent mental health restraining orders, what policy or program would you have implemented?

Response to Question 124

As per our Maori Health Plan actions we have recently audited CTOs across Auckland DHB services. This has illuminated some specific issues in treatment pathways for example Māori are on CTOs for longer than non-Māori. Areas for improvement activities along the pathway have focused on: whānau engagement (whānau involvement in care planning, treatment and discharge planning) and community engagement (whānau awareness of CTOs, and NGO involvement in CTO care plans). We await the outcome of the Mental Health Inquiry in terms of opportunities for the development of services within which we would consider CTO application. In the interim we could use additional funding to address the issues identified through service pathway audits. Primarily, we would develop a best practice guideline and protocols for clinicians working with tangata i te whaiora under a CTO. This would support the cultural responsiveness of the workforce and wider CTO service, and increase whānau engagement in treatment and support for their tangata i te whaiora. Additional health education for whānau focused on CTOs and support plans would also be included. A response would be inclusive of community mental health and social service providers to be better connected to tangata i te whaiora in the community with a CTO, and potentially a specialised kaupapa Māori mental health transition service designed to successfully integrate tangata i te whaiora into the community and transition off a CTO.

125. Given the health of Māori in your DHB in the past year, If the DHB had been given \$1M per year of new untagged funding, for 4 years, to improve Māori SUDI, what policy or program would you have implemented?

Response to Question 125

Auckland DHB has seen a substantial drop in SUDI (48% reduction between 2001-05 to 2013-17). The DHB SUDI Prevention Plan that provides an in-depth analysis of SUDI deaths across our district, particularly for Māori. Additional funding would go towards supporting and extending work already

underway and guided by this Plan. Smoking cessation remains the critical focus as a leading factor for SUDI, our joint Auckland DHB and Waitemata DHB maternal smoking incentives programme that targets hapu wahine would be at the core of our response and we would expand this programme as outlined in Question 120.

Safe sleeping education and devices (that are culturally appropriate and fit for purpose) to ensure pēpi are kept safe while they sleep until they are 12 months would also be a priority we would support with additional funding; a particular gap is pepi who need to transition from a pepi pod or wahakura into a cot. Additional streams of work would consist of supporting Māori mothers to engage with a Lead Maternity Carer (LMC) in their community who is Māori, along with culturally responsive and easily accessible parenting guidance and support. For vulnerable whānau we need to have systems in place to identify who they are early on in their pregnancy and support them through this journey until their pēpi is 5 years old. The response with these whānau would need to consider socio-economic support as whānau are experiencing many of these factors which contribute to SUDI rates and other important child health outcomes (poor housing and heating, separate and safe sleeping spaces for pēpi, breastfeeding, tobacco use, access to services, access to protective antenatal immunisation).

126. Given the health of Māori in your DHB in the past year, If the DHB had been given \$1M per year of new untagged funding, for 4 years, to improve asthma admission rates for Māori children aged 0-4, what policy or program would you have implemented?

Response to Question 126

We note that most hospitalisations for wheeze occur in preschool children, however symptoms of wheeze and breathing difficultly are usually associated with viral upper respiratory tract infections (URTI) and there has clinically been a move away from using the term 'asthma' in pre-schoolers as viral wheeze does not require asthma management (e.g. preventative inhalers). It should also be noted that respiratory hospitalisations are strongly linked to the social determinants of health, particularly housing.

Keeping children out of hospitals with potentially avoidable respiratory conditions is a metro Auckland System Level (SLM) Improvement Plan Indicator for 0-4 year olds and is monitored by ethnicity. Key activities in the Plan relevant to asthma admissions include antenatal immunisation for influenza, smoking cessation in pregnancy, influenza immunisation in eligible 0-4 year olds, and referral to Healthy Housing Initiatives. Any additional funding would be invested into supporting these existing pieces of work and implementing our SLM Improvement Plan. We would take a particular focus on additional support for pēpi vaccinations for influenza, and pertussis and influenza vaccinations for hapu wahine.

Currently Auckland DHB provides a list of eligible children to primary care practices every year based on hospital admission data. These lists do not include all eligible children as not all eligible children are admitted hospital, for example a child with Down Syndrome aged <5 years is eligible even if they have never had a hospital admission. There have been on-going issues of eligible children being refused influenza vaccine if their name is not on the lists provided. In addition, <10% of eligible Maori children on lists provided in 2017 and 2018 received an influenza vaccine compared with 20-25% of Asian children. We could invest in improving systems, however, ideally we would want to see a national universal influenza vaccination programme for children under 5 years of age rather than an eligibility-based programme as it currently is. International evidence shows that universal immunisation programmes are equity enhancing. They normalise influenza immunisation for children and remove barriers including clinicians having to decide if the child in front of them is eligible against complex criteria, and clinician concerns about vaccinating a child that is not eligible.

There is currently no system that flags eligible children for influenza vaccine that is readily available to primary care staff, and eligibility is not recorded on the National Immunisation Register (NIR). A national decision to fund universal influenza vaccine for 0-4 year olds, in addition to improving equity, would also open the door for influenza immunisation to be provided across a range of health settings thus improving accessibility. Immunising children against influenza also has a co-benefit of reducing the risk of influenza in the elderly through herd immunity.

127. Given the health of Māori in your DHB in the past year, If the DHB had been given \$1M per year of new untagged funding, for 4 years, to improve caries free dentition for Māori children aged 5, what policy or program would you have implemented?

Response to Question 127

The metro-Auckland Auckland Preschool Oral Health Plan has an explicit commitment to reduce inequity in oral health access and outcomes for Māori. Additional funding would go towards supporting and extending work already planned and underway as outlined in the Plan. Specifically, work would focus on supported enrolment and facilitate attending oral health services for Māori pēpi at birth or while engaged with other services – primary healthcare, Well Child Tamariki Ora (WCTO) providers, and resourcing providers already engaging with Māori whānau to identify tamariki not enrolled and enrol them at point of care.

Further investment would also support the enhancement of our existing fluoride varnish programme for pre-school aged children. Extending this service to all kohanga and Early Childhood Education Centres (ECEs) in selected rural communities and areas of socio-economic deprivation across our district would be a priority. This would also require an increased focus on workforce development, particularly recruitment of Māori into oral healthcare training, as well as increased Māori cultural responsiveness amongst the existing workforce, as a means to bridging the gap between oral health services and Māori communities.

Nationally, we would support investment in integration of the oral health database (Titanium) with the National Health Index (NHI).

128. Given the health of Māori in your DHB in the past year, If the DHB had been given \$1M per year of new untagged funding, for 4 years, to improve childhood obesity for Māori children, what policy or program would you have implemented?

Response to Question 128

Childhood obesity is a priority area for Auckland DHB. We have exceeded the Ministry of Health Child Obesity health target for several years.

We are a Healthy Auckland Together (HAT) partner organisation (alliance of partners to reduce childhood obesity) and we undertake actions under the HAT action plan. Auckland DHB, Counties Manukau Health and Waitemata DHB are working together on a range of health-sector led actions to address obesity prevention in the Auckland region. In 2016 the three DHBs developed the Metro-Auckland DHB Healthy Weight Action Plan for Children 2017 - 2020 ([link below](http://www.waitematadhb.govt.nz/assets/Documents/action-plans/Metro-Auckland-DHB-Healthy-Weight-Action-Plan-for-Children.pdf)), in accordance with our vision that *All tamariki in the Auckland Region of New Zealand are of a healthy weight*. The plan takes a life-course approach, focused on actions related to specific target populations: women of childbearing age, pregnant women, pre-school and school aged children and adolescents.

<http://www.waitematadhb.govt.nz/assets/Documents/action-plans/Metro-Auckland-DHB-Healthy-Weight-Action-Plan-for-Children.pdf>

Examples of obesity prevention actions in the plan include:

- Implementing the National Healthy Food and Drink Policy;
- Engaging with pregnant women and mothers to improve nutrition and physical activity levels;
- Supporting research related to healthy eating during pregnancy and gestational diabetes;
- Training GPs, primary care nurses and well child staff on having healthy weight conversations with families with overweight children;
- Delivering comprehensive, multi-component whānau-focused physical activity and nutrition programmes for overweight/obese pre-school (Positive Parenting and Lifestyle (PPAL) Programme in Auckland DHB and Waitemata DHB) and school-aged children (Active Families programme);
- Working with early-childhood education centres and kohanga reo to help them to improve their physical activity and food environments;
- Working with the Healthy Village Action Zones (HVAZ; Auckland DHB) and Enua Ola (Waitemata DHB) Pacific-church based community development programmes to encourage them to adopt water-only and healthy eating policies for church functions.

It should be noted that the Plan has an explicit equity focus as our Māori and Pacific children, as noted, have higher rates of obesity. Additional funding would go towards supporting and extending work already underway and guided by this Plan. Specifically, we would maintain support for wider community initiatives while investing more resources into culturally appropriate and targeted initiatives for vulnerable whānau. For the latter, we would support the extension of programmes listed within the Plan primarily Parenting and Physical Active Lifestyles and Healthy Babies Healthy Futures, within an intensive healthy lifestyle home based support service. This links with our responses to other questions as it would be inclusive of a range of important components for whānau with children to 5 years – SUDI prevention, promotion of breastfeeding and immunisations, enrolment and engagement with services and healthy housing.

129. What 3 treatable health conditions within the health portfolio have the biggest impact on Māori health in your DHB listed by order of impact?

Response to Question 129

The response to this question depends on how 'treatable' is defined, and also on treatment effectiveness; how much potential health gain can 'treatment' provide. Treatable could also be viewed in a wider context and include conditions that are preventable.

We have defined 'treatable conditions' as those with the greatest impact on mortality, in particular using the indicator of *amenable mortality*. Amenable mortality is a routinely reported indicator defined as premature deaths (deaths before age 75 years) from conditions that could potentially be avoided, given effective and timely care for which effective health interventions exist. In 2015, we estimate that 57 Maori deaths (or a rate of 158 per 100,000 population) in Auckland DHB were potentially amenable. Amenable mortality rates for Maori have steadily decreased over time.

For Auckland DHB the three leading causes of amenable mortality in Maori (2013 to 2015) are Coronary Disease (34 Maori deaths), Diabetes (24 Maori deaths) and Female Breast Cancer (17 Maori deaths). We note that lung cancer does not feature in this analysis because it is not considered amenable according to the Ministry of Health definition; the high impact of lung cancer is detailed in the response to Question 135. Previous analysis has shown that mortality from conditions considered amenable contributes approximately 3.2 years to the Maori life expectancy gap (life

expectancy in Maori compared to non-Maori/non-Pacific, 2012-14). The aforementioned three amenable conditions contribute approximately 1.2 years to the life expectancy gap.

We have developed a Māori pipeline of initiatives, projects and programmes of work specifically targeted at achieving Māori health equity. The Māori Health Pipeline is an initiative started in 2017/18 led by the Māori Health Gain Team and Health Gain Teams (Planning, Funding and Outcomes) to accelerate specific projects that aim to improve Māori Health and close the life expectancy gap, inclusive of amenable mortality. We would invest additional funding into further development of activities under the pipeline including developing a lung cancer screening pilot, alternate models of cardiac and pulmonary rehabilitation and breast and cervical screening (please see response to Question 118).

130. Given the health of Māori in your DHB in the past year, what single health portfolio policy could central government have deployed to improve the health of Māori in your DHB?

Response to Question 130

The determinants of health have a larger impact on health outcomes than healthcare services. Outside of income, housing would be the single portfolio of focus that would link with health sector interventions such as Kainga Ora – Healthy Homes Initiative as outlined in our response to Question 122.

131. Given the health of Māori in your DHB in the past year, If the DHB had been given \$1M per year of new untagged funding, for 4 years, what Māori health portfolio initiative would you have advanced and what would be the measurable outcome measures?

Response to Question 131

We have developed a pipeline of initiatives specifically targeted at accelerating Maori health equity and further narrowing the Maori life expectancy gap (called the Maori Health Pipeline). This programme of work encompasses the leading causes of death for Maori in our district and focused areas of health gain aligned with our Maori Health Plan. Current work includes development of a lung cancer screening pilot, alternate models of cardiac and pulmonary rehabilitation and breast and cervical screening projects. Our Maori pipeline provides an opportunity to innovate, pilot and implement new service delivery models that improve the quality of services, access to services, and outcomes, for Maori whānau. Given the high profile and potential impact of this work new funding would further resource activities within the Maori pipeline.

132. Given the health of Māori in your DHB in the past year, If the DHB had been given \$5M per year of new untagged funding, for 4 years, what Māori health portfolio initiative would you have advanced and what would be the measurable outcome measures?

Response to Question 132

We have developed a pipeline of initiatives specifically targeted at accelerating Maori health equity and further narrowing the Maori life expectancy gap (called the Maori Health Pipeline). This programme of work encompasses the leading causes of death for Maori in our district and focused areas of health gain aligned with our Maori Health Plan. Current work includes development of a lung cancer screening pilot, alternate models of cardiac and pulmonary rehabilitation and breast and cervical screening projects. Our Maori pipeline provides an opportunity to innovate, pilot and implement new service delivery models that improve the quality of services, access to services, and outcomes, for Maori whānau. Given the high profile and potential impact of this work new funding would further resource activities within the Maori pipeline.

133. In the past year, what treatable health portfolio condition have had the greatest health disparity for Māori versus non-Māori in your DHB and how would you go about addressing it and at what fiscal cost and over what time frame to achieve a measurable change?

Response to Question 133

As per the response for Question 129, the answer to this question depends in part on how 'treatable' is defined, and also treatment effectiveness – how much potential health gain can 'treatment' provide. It could be defined more narrowly as impacting on mortality and in particular amenable mortality.

Addressing broader prevention strategies – being smokefree (e.g. smoking cessation incentives programme), healthy nutrition, being physically active, keeping a healthy weight, minimal alcohol, and management of cardiovascular risk - will bring benefits for these conditions. In addition, whole of government initiatives to address the social determinants of health (e.g. housing, income, education) will have impacts along the prevention/ treatment/palliative care continuum. There will also be specific strategies required to address gaps identified along that continuum for the specific conditions. The costs of these strategies would be spread across many conditions and are local/regional/national actions rather than being DHB specific.

134. Given the health of Māori in your DHB in the past year, what single health portfolio policy would you have implemented to reduce any differences between Māori and non-Māori for the most commonly diagnosed cancer in Māori, and at what fiscal cost per annum and over what time frame to achieve a measurable change?

Response to Question 134

For 2014-16, in all three metro Auckland DHBs, the top registered cancer in Māori was lung cancer.

1. Lung (66)
2. Breast (64)
3. Prostate (41)

Top registered cancers for Auckland DHB 2014-16 (number of registered cancers)

	Maori	Non-Maori
Breast	66	796
Lower GI	64	727
Haematological	41	675
Prostate	39	653
Lung	36	487

We have also included a table with a further breakdown of non-Māori into Pacific, Asian and Other groups. This is important context where the heterogeneity of our non-Māori populations impacts the Te Tiriti o Waitangi perspective of the differences between Māori and non-Māori (in particular health inequities for the Pacific population can mask the degree of inequities for Māori). Also, Pacific and Asian peoples represent substantial percentages of our metro Auckland DHB populations, and it is important their needs are visible and addressed in our health service planning.

Top registered cancers for Auckland DHB 2014-16 (number of registered cancers by ethnicity)

Asian		Māori		Pacific		Other	
Breast	135	Lung	66	Breast	87	Melanoma	574
Lower GI	112	Breast	64	Lung	61	Breast	554
Haematological	76	Prostate	41	Prostate	60	Lower GI	539
Prostate	70	Lower GI	39	Upper GI	55	Prostate	528
Lung	68	Upper GI	36	Haematological	54	Haematological	365

Lung cancer

There is a substantial inequity in lung cancer rates: age-standardised lung cancer registration rate (per 100,000) for Maori in Auckland DHB is 68.4 vs. NZ European rate of 23.3 (Pacific rate 44.0 and Asian rate 18.4; time period for analysis 2012-14). In 2012-14 higher lung cancer mortality rates contributed 0.8 years to the Māori life expectancy gap in Auckland DHB and Waitemata DHB (Māori vs. Non-Māori/non-Pacific).

In terms of interventions to address lung cancer and inequities for Maori, smoking cessation remains a critical intervention and there is scope to extend incentives to all Maori smokers (rather than pregnant women and their whānau as currently). We have prioritised the development of a lung cancer screening pilot in our Maori Health Pipeline to address the existing substantial inequity in cancer incidence and mortality for Maori, aiming to detect cancers earlier and at a more treatable stage.

135. What is the most significant single treatable hearing disorder for Māori in your DHB across any age group and what percentage of Māori in your DHB have, or have had, this condition?

Response to Question 135

There is no one data source for information on individual hearing disorders, nor a definition for what might be considered 'treatable'. However, the New Zealand Disability Survey 2013 gives national rates of hearing disability for Maori. Applying these rates to local populations provides an approximation of the numbers with hearing disability. This assumes that the national rates are accurate for local populations, and have not changed greatly since the 2013 survey.

Hearing - Total NZ - disability rate 2013

	All ages	0–14	15–44	45–64	65+
Maori	8	2	7	14	32
All ethnicities	9	1	4	11	28

Estimated number of Maori with hearing disability in metro Auckland DHBs, 2018/19

	All ages	0–14	15–44	45–64	65+
Auckland DHB	3,470	212	1,486	1,201	950

The National Deafness Notification Report 2017 states that Māori children and young people (0-19 years) are over-represented in notifications (notification rate was 33% whilst they account for only 22% of the population). This report also notes that Māori children and young people are still likely to have a delayed diagnosis however reassuringly they were more likely to have hearing aids fitted, although this is in part because they are more likely to have bilateral hearing loss. This report also notes that Māori children were more likely to have a referral following a B4School Check (9%) in 2011 than non-Māori (5%),

For children, otitis media is significant, and many previous reports have noted that Maori children have higher rates of otitis media and recurrent respiratory infections. A focus on prevention of respiratory illnesses more broadly for children – for example through influenza immunisation, housing improvements and higher immunisation coverage (e.g. pneumococcal vaccine) is relevant for hearing conditions as well as preventable respiratory hospitalisations.

136. What significant treatable hearing disorders do Māori have in your DHB listed by age groups of preschool, school age (primary and secondary), adults, older people (65+), and for each age group, identify a single intervention policy and cost per annum for 4 years to make significant hearing improvements in that group?

Response to Question 136

See response to Question 135, including disability survey results.

There is no one data source for information on individual hearing disorders, nor a definition for what might be considered 'treatable'. The latest National Screening Unit (NSU) new-born hearing screening monitoring report covers the whole of New Zealand for the 2015 calendar year and contains the table below. This data may not necessarily be considered 'treatable' though, except with hearing aid:

Link to report:

<https://www.nsu.govt.nz/system/files/page/unhseip-monitoring-report-january-december-2015-jan17.docx>

Before School Check (B4SC) hearing screening results – Auckland DHB

A higher proportion of Maori children than other ethnicities are found to have hearing issues and referred for treatment, or are not checked.

B4SC Auckland DHB, children turning four in the calendar year: 2017 (DOB 01/01/2013 - 31/12/2013)

Hearing Check Outcome	NZ Maori	Pacific	Asian	European/ Other	Total
Pass Bilaterally	70%	65%	77%	80%	75%
Rescreen	10%	19%	12%	8%	12%
Referred	10%	9%	6%	5%	7%
Under care	5%	2%	3%	4%	3%
Decline	0%	1%	0%	1%	0%
Not checked	5%	4%	2%	3%	3%

An important focus of any policy implemented would be to identify mild, moderate and severe hearing loss early amongst Māori pēpi and tamariki so that support can be arranged to prevent, treat and/or ameliorate hearing loss so it does not affect further development. Particularly important for Māori is the development of appropriate screening, diagnostic and intervention policies and practices, which ensure early detection and allow more effective interventions for whānau. This includes refining our B4 School Check programme to ensure whānau are engaging in this programme. As noted previously, healthy housing conditions, parental smoking cessation programmes and immunisation are important to prevent hearing conditions.

137. What differences are there in the incidence of dementia and Alzheimer's in Māori compared to non-Māori in your DHB and how would you reduce any differences and at what cost per annum?

Response to Question 137

Incidence and prevalence of dementia is highly age dependent. 19% of Maori and 14% non-Maori were identified as having dementia in a longitudinal cohort of 937 people initially aged 80 to 90 years for Maori and aged 85 years for non-Maori in the LiLACS NZ study in the Bay of Plenty. In the LiLACS study dementia was recorded based on results of validated self-report screening tests.

Sources: LiLACS study of older adults in the Bay of Plenty (University of Auckland (2017) Dementia. Supplementary Findings from LiLACS NZ for Section Five, 'Service Use and Common Health Conditions' in the report 'Health, Independence and Caregiving in Advanced Age')

The key strategies for prevention of dementia are similar to prevention of other common non-communicable diseases – being smokefree, healthy nutrition, being physically active, keeping a healthy weight, minimal alcohol, and management of cardiovascular risk. The costs of these strategies would be spread across many conditions and are local/regional/national actions rather than being DHB specific.

138. Given the health of Māori in your DHB in the past year, what single health portfolio policy would you have implemented to reduce any differences between Māori and non-Māori for Glue Ear in children, and at what fiscal cost and over what time frame to achieve a measurable change?

Response to Question 138

Please see responses to Question 135 and Question 136.

As noted previously, healthy housing conditions, parental smoking cessation programmes and immunisation are important to prevent hearing conditions. In addition, identifying children with otitis media for grommet insertion when appropriate is important, as is ensuring that classroom design and school environments support their learning. Many modern classroom designs disadvantage children with impaired hearing and other needs.

139. What significant treatable vision disorders do Māori have in your DHB listed by age groups of preschool, school age (primary and secondary), adults, older people (65+), and for each age group, identify a single intervention policy and cost per annum for 4 years to make significant hearing improvements in that group?

Response to Question 139

The most significant 'treatable' vision disorders (as considered by our clinicians) by age group would be:

- Children: uncorrected refractive error and keratoconus
- Adults, uncorrected refractive error, diabetic retinopathy, cataract
- Older: cataract, diabetic retinopathy, glaucoma

Interventions relevant to these conditions are as follows:

Children

Improve Maori access to the spectacle scheme, given it is targeted at low income. Parent education through targeted media campaigns, group parenting sessions and individual whānau education would support an increase of understanding of conditions, what to look for amongst children and where to seek further support. Māori specific pathways from screening, to treatment to on-going care would also support addressing barriers experienced by many whānau.

Adults/Older

Establish a national database and screening programme for diabetic eye disease. The UK has managed to reduce the rate of blinding diabetic retinopathy using this approach, so that it is not the most common cause of blindness in the working age population whereas in New Zealand it is still the commonest cause. Alternatively policies to lower barriers to optometry (primarily cost) could improve access.

Additional Comments

Red eye reflex testing is undertaken on neonates to check for a range of vision issues that may result in blindness. Conditions tested for are relatively rare, but have a significant impact if not identified and managed early. Vision and hearing testing occurs as part of the B4 School Check, or at age 5 years if a child has not had a check. The test is for amblyopia (lazy eye). This does not identify whether a child needs corrective lenses as is often commonly assumed by families. There is evidence to suggest that the current age and tests performed should be reviewed. It is expected that this will be addressed through the Ministry of Health led Well Child Tamariki Ora Review. Obtaining expert clinical advice is expected to be part of the review process.

140. What is the most significant single treatable vision disorder for Māori in your DHB across any age group and what percentage of Māori in your DHB have, or have had, this condition?

Response to Question 140

Please see response to Question 139

141. Given the health of Māori in your DHB in the past year, what single health portfolio policy could central government have deployed to reduce methamphetamine use by Māori in your DHB?

Response to Question 141

Mental health and other outcomes can be improved by interventions aimed at supporting positive family functioning and developing skills such as social problem-solving, communication and social skills in the adolescent years. Effective interventions are multi-pronged. At the individual level care must focus on the promotion of protective factors, skills and competencies in young people, while care also needs to address wider environment factors being experienced by the individual. We would support a whānau based intervention that addresses individual and environmental risk factors (for

example, providing intensive counselling), while also building protective factors like whānau resilience and cultural development.

142. Given the health of Māori in your DHB in the past year, if the DHB had been given \$1M per year of new untagged funding, for 4 years, how would you have used this money to reduce methamphetamine use by Māori in your DHB and what would be the measurable outcome measures?

Response to Question 142

We would deliver a comprehensive prevention programme that focuses on preventing methamphetamine use in our community. Effort will be directed at rangatahi (youth people) and their whānau. We will work in collaboration with a myriad of agencies to identify and assess individuals at risk of developing substance abuse issues.

Rangatahi are at greater risk of turning to, using, and abusing substances due to their heightened exposure to environmental risk factors including lack of supervision, witnessing alcohol and drug use within the home and access to substances, and individual risk factors like an inability to cope with stress, their attitudes towards alcohol and drug use, and low self-esteem. The primary aim of this service is to improve resilience amongst young Māori in order to prevent their use of harmful substances like drugs and alcohol.

Outcomes:

1. Increased self confidence
2. Improved whānau relationships
3. Increased engagement in education/training
4. Increased resilience
5. Increased cultural identity and connectedness
6. Improved problem solving skills
7. Improved mental health

143. Given the health of Māori in your DHB in the past year, if the DHB had been given \$5M per year of new untagged funding, for 4 years, how would you have used this money to reduce methamphetamine use by Māori in your DHB and what would be the measurable outcome measures?

Response to Question 143

If funding were increased, we would expand the scope of the service above to include prevention services for non-Māori and adults who are also at-risk of developing substance abuse issues. We would also look at co-designing and delivering with Māori a treatment service for people who are currently using methamphetamine.

1. Increased self confidence
2. Sobriety and days without MA use
3. Improved whānau relationships
4. Increased engagement in education/training
5. Increased resilience
6. Increased cultural identity and connectedness
7. Improved problem solving skills
8. Improved mental health

144. Does the DHB support lowering prescribing costs for Māori (given Māori are over-represented in unmet need statistics) and if not, why not?

Response to Question 144

Auckland DHB is committed to achieving Māori health equity and accelerating Māori health gain. Our DHBs support initiatives across the entire spectrum of care that address unmet need for Māori, moreover we support initiatives that keep Māori healthy and well, so that they only need minimal engagement with the health system. Māori over-representation in unmet health needs is better looked at by taking a whole of system approach, inclusive of alleviation of poverty, socio-economic determinants of health, housing, health literacy, modifiable risk factors, access to health services, quality of care and health workforce development. Simply lowering prescription costs on its own is not a valuable solution without considering other key factors that underpin the reasons why whānau may not pick up their prescription, whether a prescription is a priority for them at this time, or even needed. Instead, solutions need to be considered in the wider context of health service planning, funding and delivery to determine their effectiveness and value to Māori and the system.

145. How does the DHB apply the Treaty of Waitangi principles of Partnership, Participation and Protection to its health strategies?

Response to Question 145

Auckland DHB recognises Te Tiriti o Waitangi as the founding document of New Zealand. We commit to the intent of Te Tiriti that established Iwi as equal partners with the Crown through several mechanisms.

Our Annual Plans feature the four Articles of Te Tiriti to provide a framework for developing a world-class health system that honours the beliefs and values of Māori patients, that is responsive to the needs of Māori communities, and achieves equitable health outcomes for all. In addition to an annual statement about Te Tiriti, our Annual Plan is signed-off by our Treaty of Waitangi partners – Ngāti Whātua and Te Whānau o Waipareira, as proof of our commitment to this partnership.

Article 1 – Kawanatanga (governance) provides active partnerships with mana whenua and urban Māori at a governance level. In 2001, we signed our Memorandum of Understanding (MoU) with Ngāti Whātua, and in 2003 with Te Whānau o Waipareira. The MoUs embed engagement with Māori communities, represented by the above organisations, in decision making, oversight, planning and funding across the DHB. Both partners appoint representatives to our Māori Health Gain Advisory Committee (Manawa Ora) to represent the views of their communities. Both are also represented on our District Alliance Leadership Team (ALT) and are present at a number of decision making forums aligned to their priorities.

Article 2 – Tino Rangatiratanga (self-determination) is concerned with opportunities for Māori leadership, engagement, and participation in DHB activities. Since 2012, we have resourced Ngāti Whātua and Te Whānau o Waipareira with funding to ensure their participation and leadership in Māori health. Their presence and guidance across procurement processes, development of new models of care and community engagement are critical for achieving Māori health equity. This partnership has seen the development of our Kaumātua Strategy, which is designed to prepare our services for an increasing number of Māori reaching older age, completion of the Whānau House Health Needs Assessment (HNA) which has seen significant investment of new funding and resources to West Auckland, and completion of the Māori Workforce Development Strategy that challenges Auckland and Waitemata DHBs to increase the number of Māori we employ and develop into senior leadership roles.

Article 3 – Oritetanga (equity) is concerned with achieving Māori health equity. Our Annual Plan makes an explicit commitment to "Reducing the ethnic gap in life expectancy at birth", with additional equity focused targets expressed throughout the Plan, our System Level Measures Improvement Plan, and Māori Health Plan. Our CEO has a Maori health equity scorecard reported regularly.

In addition to targets, we monitor the achievement of equity for Māori through our Auckland and Waitemata DHBs Māori Health Scorecard. The Scorecard, which is received quarterly by Manawa Ora (Maori Health Gain Advisory Committee to the Board), provides a snapshot of the DHBs' performance in relation to key Māori health targets. Some targets are set nationally by the Ministry of Health including cancer screening and primary care enrolment, while some are set locally including Māori health workforce numbers and hospital engagements by our Māori health services.

Having the Scorecard featured so prominently and publicly allows for performance issues to be identified and discussed in this forum. Following analysis at Manawa Ora, recommendations and advice are usually addressed directly to the relevant DHB executive responsible for the service in question. This allows advice from the community, and governance, to go directly to the DHB executive level to achieve rapid implementation and positive change.

We have also developed a Māori health pipeline of projects. These projects specifically aim to reduce the life expectancy gap between Māori and non-Māori by addressing areas of greatest inequity for Māori. These projects span cancer (lung, cervical and breast) screening and prevention, pulmonary and cardiac rehabilitation and secondary prevention, and a healthy and well lifestyle programme.

Article 4 – Te Ritenga (right to beliefs and values) guarantees Māori the right to practise their own spiritual beliefs, rites and tikanga. Waitemata DHB honours the beliefs, values and aspirations of Māori patients, staff and communities across all activities. Dame Rangimarie Naida Glavish is our Chief Advisor Tikanga and is a member of our Executive Team. This position is regional, spanning across Auckland and Waitemata DHBs, and jointly appointed by Ngāti Whātua. Dame Naida and her team play a pivotal role in ensuring tikanga Māori is observed across our activities. This includes implementation of, and training for clinicians to implement, our Tikanga Best Practice Policy, and oversight of our kaumātua workforce who support Māori patients by providing cultural support and guidance in their care.

Question 145 – Appendix 1

Question 145 – Appendix 2

Links to documents found our websites:

ADHB and WDHB Maori Health Plan:

<http://www.adhb.health.nz/assets/Documents/About-Us/Planning-documents/2017-18-Maori-Health-Plan-Auckland-and-Waitemata-DHBs.pdf>

SLM Improvement Plan:

<http://www.waitematadhb.govt.nz/assets/Documents/health-plans/metro-auckland-2017-2018-SLM-Plan.pdf>

ADHB Annual Plan:

<http://www.adhb.health.nz/about-us/planning-and-funding-2/planning-documents/>

WDHB Annual Plan:

<http://www.waitematadhb.govt.nz/dhb-planning/organisation-wide-planning/annual-plan/>

ADHB and WDHB Kaumātua Action Plan:

<http://www.adhb.health.nz/assets/Documents/About-Us/Planning-documents/ADHB-Kaumatua-Action-Plan-2015-18.pdf>

146. Does the DHB have plans to tackle New Zealand's family violence issue via the health sector?

Response to Question 146

The ADHB delivers the MOH Violence Intervention Programme (VIP) training and support to health professionals employees, ensuring alignment with the Family Violence Intervention Guidelines: Child and Partner Abuse. (MOH 2016) The programme aims to reduce and prevent the negative health and social impacts of family violence and child abuse and neglect through early identification, assessment and referral of victims presenting to health services in hospital and community settings by improving DHB responsiveness.

The VIP programme is implemented into the MOH identified services of Child Health services, Maternity services and all of Mental health. ADHB is currently redesigning our strategy to achieve better implementation in ED. In collaboration with Oranga Tamariki, the Police and Ngāti Whātua, ADHB has also begun an overhaul and expansion of our regional Child Advocacy Centre (Puawaitahi) - a unique model of collaboration which is tackling family violence through the integration of advanced multi-agency child protection practice with community family violence advocates and the VIP programme. In this model, the ADHB has 21 FTE (social workers, paediatricians and paediatricians in training, nurse specialists, psychologists, VIP and child protection co-ordinators and administrative staff) funded specifically for family violence intervention and case-work in child protection (a local, regional and national service). ADHB is also working collaboratively with the Auckland City Police to implement the new Whangaia Nga Pa Harakeke programme. The model aims to respond more effectively to family harm and move to a prevention (rather than intervention) model. The model includes representatives from Health, Corrections, Oranga Tamariki, ACC and Police. The group will review all family harms for the community and share information and work together to develop a plan to put supports in place for both the victim(s) and perpetrator.

147. How will the DHB support and fund routine enquiries by health professionals to ensure all women are asked about family violence and referred to appropriately funded family violence services?

Response to Question 147

The ADHB have four Violence Intervention Programme co-ordinators (2.5 FTE in one full-time and three part-time positions, one of which is an employee of SHINE, the largest violence intervention NGO in Auckland) and a Child Protection coordinator who are responsible for leading the programme of training staff in routine enquiry, policy development, auditing and supporting staff. There is also one SHINE family violence advocate on site, funded by the ADHB. This person undertakes safety assessments and planning with ADHB patients and whānau on-site and ensures

referral processes to wider Shine* services are kept updated and accessible to ADHB social workers and staff. There are approximately 128 VIP champions or family safety facilitators across these services to provide on the floor support to their peers and ensure the policies are adhered to. These champions have chosen to add this responsibility to their usual roles within their clinical teams.

The focus is on providing a comprehensive training package and support to front-line clinicians. Representatives from Puawaitahi, SHINE, the Police Family Violence Team and Oranga Tamariki deliver the training. The objective is to increase clinicians' confidence and knowledge and enable continuous improvement in the quality and consistency of routine enquiry by all professional disciplines across the organisation. The co-ordinators are available for support along with ADHB social workers in all branches of health service delivery (hospital and community), Puawaitahi and the Oranga Tamariki ADHB Liaison Practice Leader.

There is specific funding from the MOH for the development of the training packages and one coordinator role, but all other funding has been provided by prioritising within the ADHB.

148. What is the DHBs position on the delayed introduction of HPV testing to 2021?

Response to Question 148

The delay to implementing human papilloma virus (HPV) primary screening for the National Cervical Screening Programme (NCSP) is disappointing. The HPV primary screening changes planned for the NCSP are evidence based and the National Screening Unit should implement the shift in screening as soon as is practicable to maintain a screening programme that is designed around current best practice.

However, the delay to the implementation of HPV primary screening provides an opportunity to include HPV Self-Sampling for women as a central part of the changes to the programme. In the intervening period since the HPV testing programme changes were designed, evidence supporting the efficacy of HPV self-testing has improved and the Cochrane collaboration now confirm that self-sampling is as effective as clinician-taken samples for testing for HPV. At Auckland DHB we support the implementation of HPV self-testing for all women who would prefer this option. The potential for a significantly improved experience for women presented by this self-test option is expected to have a positive equity impact on participation in cervical screening. As noted in the response to Question 117 Auckland DHB and Waitemata DHB have invested in the completion of a HPV self-sampling feasibility study for Māori women, and are now supporting the larger clinical trial of invitation methods including Māori, Pacific and Asian women. Self-sampling is a promising intervention that could provide a step-change in coverage, therefore clearly establishing evidence on how unscreened and underscreened priority women, particularly Māori women, respond to this technology and how it can be optimised is important and further investment is warranted.

It is acknowledged that implementing the HPV primary screening programme will rely upon a new NCSP register infrastructure. The replacement of the register presents an important opportunity for improved infrastructure. It is important that the new register is a fully integrated population register; that incorporates the capacity to integrate effectively with all primary care patient management systems (providing point-of-care information on screening status and eligibility for free screening), as well as quality referral systems and integrated options for providing updated information to the register itself. The delay to implementing HPV primary screening for NCSP also includes a delay in upgrading the NCSP register. In the meantime, considerable effort is required to work around the existing architecture of the register which would be better spent providing targeted support to women who are not well engaged with the NCSP programme.

The communication around the delayed implementation and then around the implementation of the change in age of entry into the screening programme of 25 year (previously intended to be part of the change to HPV primary screening), created confusion amongst health professionals, including primary care who are the mainstay of delivering the cervical screening programme in New Zealand. This has impacted coverage rates.

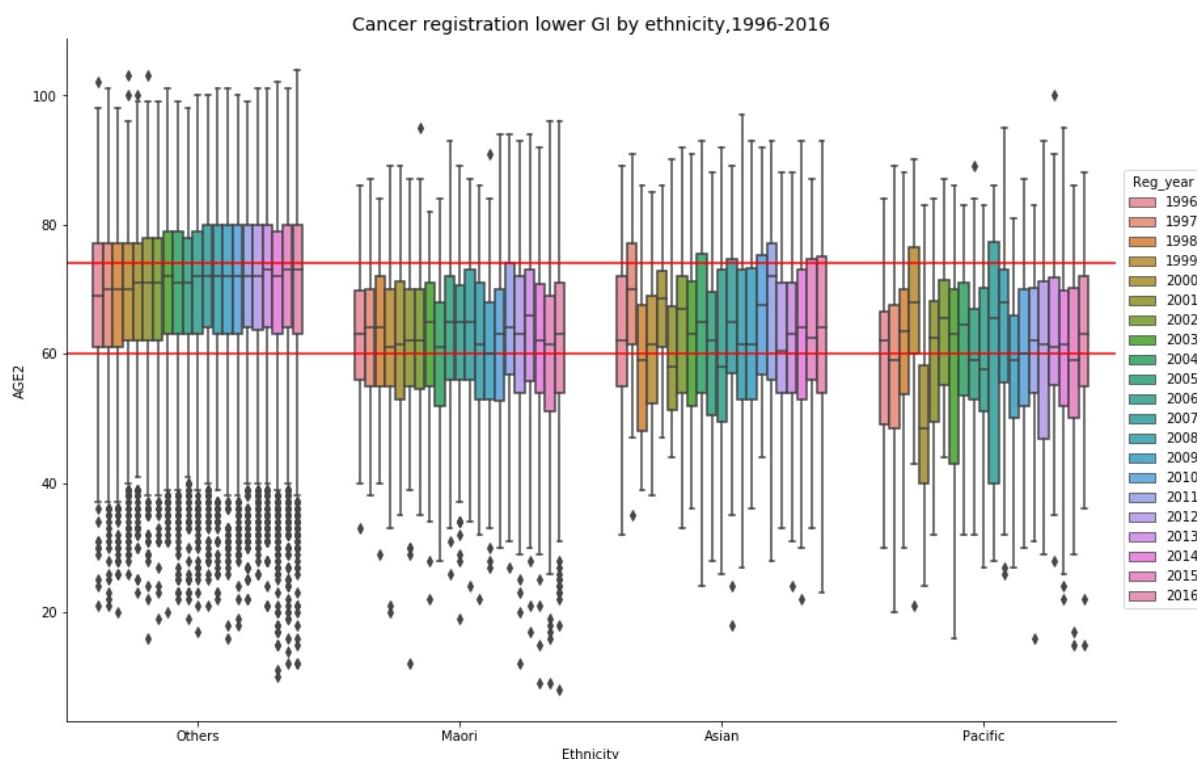
149. There is concern regarding the design of the National Bowel Screening Programme. The programme as it is currently designed will increase inequity. How will the DHB support, advocate and or address this?

Response to Question 149

Auckland DHB is working closely with Waitemata DHB who provide the regional support function for the roll out of the bowel screening programme.

We recognise the potential for the programme as designed to increase inequity at all points along the screening pathway – in particular the eligible age range for participation.

As part of a programme of work examining cancer equity in the Northern Region (under the Northern Region Integrated Cancer Board) we have undertaken a range of analyses. One analysis, on bowel cancer is presented below; This shows a box and whisker plot of the age range of bowel cancer diagnosed between 1996-2016 (national data) by ethnicity. The red lines are the current bowel screening programme eligible ages. This clearly demonstrates that most Other ethnicity (NZ European, MELAA and other ethnicities) cancers are in this age range, however this is not the case for Maori, Pacific or Asian.



Source: NZ Cancer Registry

As an outcome of the Ministry of Health convened National Maori Hui held in August, considering the revising the eligible age range for Maori, we are pleased to note that the Ministry has convened a larger meeting of Maori academics, professionals and health service experts which will take place in February 2019. The meeting will:

- consider the evidence for lowering the screening age range for Maori
- consider proposals to increase coverage for Maori
- review a plan to monitor trends in Maori incidence
- make recommendations with regards to the overall equity approach.

We support the inclusive and consultative approach to this issue which this meeting provides.

150. How many surgical mesh procedures were undertaken in the past year listed by SUI, POP, Abdominal and other?

Response to Question 150

SUI: 36 TVTs

POP vaginal mesh: Nil (since 2014)

Abdominal: Sacro-colpopexy: 7

Other: Nil

151. How many surgical mesh reversals were undertaken in the past year listed by original procedure SUI, POP, Abdominal and other?

Response to Question 151

In Women's Health there were 11 vaginal mesh complications in total of which eight were originally placed in other DHB's and seen as tertiary referrals. These compromised 8 TVT's and 3 POP's.

There were no mesh reversals undertaken in other specialties

152. Give an estimate of surgical mesh procedures undertaken in private listed by SUI, POP, Abdominal and other?

Response to Question 152

With regards to the Urogynaecologist/gynaecologists working at ADHB and in private practise, 40 TVTs and 7 sacrocolpopexy operations were performed in the 2017 year.

153. What policy changes were made in the management of surgical mesh procedures over the year, listed by policy change, author of the policy change, date, and results of policy compliance monitoring?

Response to Question 153

There has been no change in policy at the Auckland DHB. In 2015, the women's health team stopped offering transvaginal mesh for prolapse. Mesh is used in General Surgery largely for abdominal wall hernias. Whilst there has been no policy change, the New Zealand Association of General Surgeons policy statement of mesh use for abdominal wall hernia is frequently referred to in consultation.

154. How many complaints were received for surgical mesh related procedures in the past year listed by SUI, POP, Abdominal and other?

Response to Question 154

In financial year 2017/18 Auckland DHB has identified 1 complaint about the use of mesh. This related to the historic use of urogynaecological mesh.

155. Is the DHB capable of retrospectively entering all vaginal mesh procedures over the past 4 years into a retrospective surgical mesh register albeit by manual or electronic means or both, that is, does the DHB have capacity to undertake this task ?

Response to Question 155

Yes, Women's Health has a surgical database that we can pull this information from.

156. If a retrospective register of all vaginal mesh procedures was undertaken for the past 4 years, provide an estimate of how many new data points would be entered into the register and estimate the number of person hours required and the cost of retrieving and entering this information?

Response to Question 156

14 data-points (NHI, age, ethnicity, indication for surgery, surgeon, type of mesh, length of surgery, complications during surgery, complications < 6 weeks post-surgery, 6 weeks FU, 6 M FU, 1 year FU, QOL pre- and postop). 320 SMO hours for retrieving and entering information. 20 hours (epidemiologist) for data quality control.

157. Is surgical mesh that is used in procedures such as SUI and POP tracked electronically within logistics and inventory systems all the way to the patient, and if not, how far is it tracked electronically and is it batch and bar coded on that journey?

Response to Question 157

Clinical notes for all patients with implanted surgical mesh record a barcode with batch and lot numbers. Surgical mesh is not otherwise tracked electronically to a specific patient within logistic and inventory systems.

158. How many surgical specialists are credentialed for older surgical procedures for SUI and POP such as colposuspensions?

Response to Question 158

Women's Health: 3 specialists are credentialed for colposuspension. 3 for fascial sling and 4 for urethral bulking.

159. Does the IT management system have the ability to use a deprecated ACHI procedure code as a temporary proxy for vaginal mesh procedures such as SUI and POP, and if so what level of resource would be required to deploy this on a scale of mild, moderate or severe?

Response to Question 159

This question was posed to the NZ Coding Authority who have advised that there is no appropriate deprecated ACHI procedure code for this purpose. If this was possible, the resource required to deploy would be significant as this would need to be integrated with 3M Codefinder and there would be issues with using a code that is not part of ICD-10-AM 8th Edition and it would affect the grouper (which would reject all events with a code outside of 8th edition). The description is

currently being edited to include mesh as an alternative means of capturing this data when vaginal mesh is used in a surgical procedure, If no mesh is used; this is also edited into the procedure description

160. What proportion of patients receiving vaginal surgical mesh are told they are having a TVT or tape procedure or insertion as compared to a mesh insertion?

Response to Question 160

All are advised a tape is made of mesh

161. Please copy paste any patient advice and an example consent form for patients who have received surgical vaginal mesh procedures in the past year.

Response to Question 161

We provide patient with the IUGA pamphlets on their procedure

<https://www.yourpelvicfloor.org/leaflets/>

The Standard Hospital Consent for Surgery is used.

162. How many surgeons have in total undertaken mesh removal/revision procedures at your DHB facility in the last year?

Response to Question 162

Four surgeons in Women's Health are credentialed for mesh removal and have undertaken mesh removal in the last year.

163. How many surgeons will undertake mesh removal/revision procedures from the 8th of October 2018?

Response to Question 163

As from 8 Oct 2018, four surgeons in Women's Health are credentialed for mesh removal and or revision procedures. Mesh removal for abdominal wall mesh is within credentialing for General Surgeons, and pelvic mesh removal within scope for Colorectal Surgeons. However, the numbers of mesh removal or revisions procedures is low in the General Surgical sub-specialties.

164. What information does your DHB document in regards to mesh revision surgery?

Response to Question 164

The numbers of mesh revision surgeries from 2017 are captured in the Women's Health Annual Clinical Report, which is widely available on our website.

<http://www.adhb.health.nz/>

165. Please clarify what information is collected/reported in regards to mesh revision surgery and does this include details such as trimming of mesh, partial and full removal?

Response to Question 165

Information in regards to mesh revision surgery is recorded in the operating notes. Mesh revision operations are currently coded on the Women's Health database as 'urogynaecology-other'.

166. How many surgeons meet the Australasian mesh credentialing requirements and are able to continue implanting and removing surgical mesh for stress urinary incontinence, have provided the two yearly documentation which is required now by the MOH?

Response to Question 166

4 surgeons are credentialed to implant and remove surgical mesh for SUI.

167. What is the ratio of GPs per capita?

Response to Question 167

Unique GPs: 527

Number of GPs per 100,000
population: 99

Data based on Q2 2018. The above is unique GP numbers (based on medical council ID). If the GP is listed as working at multiple practices within the same DHB they are only counted once in that DHB. If they work in a practice in both Auckland and Waitemata they are counted once in each DHB.

Note: Auckland DHB is not able to provide full time equivalent (FTE) numbers of GPs. The number of GPs per 100,000 population is not a good measure of either coverage and or access. FTE GPs per 100,000 people would be a superior measure of coverage and access.

168. What is the age profile of GPs?

Response to Question 168

Auckland DHB does not collect data on the age of the GP workforce. Please refer to the Royal New Zealand College of General Practitioners survey.

169. What proportion of GPs have primary medical qualifications from overseas?

Response to Question 169

Auckland DHB does not hold this information. Please refer to the Royal New Zealand College of General Practitioners survey.

170. How many GP training places are there and how many GP training practices?

Response to Question 170

Auckland DHB does not hold this information. The Royal New Zealand College of General Practitioners manage the General Practice Education Programme (GPEP).

171. What percentage of GP training places were filled last year?

Response to Question 171

Auckland DHB does not hold this information. The Royal New Zealand College of General Practitioners manage the General Practice Education Programme (GPEP).

172. How many VLCA practices are in the DHB area?

Response to Question 172

53

173. What is the anticipated effect on GP utilization of increased community mental health services and will GPs be compensated for increased utilization and if so by what mechanism?

Response to Question 173

Increased community mental health services will have a number of positive benefits for general practice. These benefits will be to have an alternative to and or adjunct to medication alone and patients will be able to access support outside the general practice. The DHB experience with Awhi Ora and the Fit for Future study (included use of Health Improvement Practitioner (HIP) and Health Coach roles in General Practice) is that increasing the range of community services resulted in: direct contribution to improved mental health and wellbeing outcomes for people accessing support; increasing access for Māori, Pacific and youth, benefits for staff confidence and capacity in practices with these roles and early but emerging contributions to wider benefits for practices and the health system. This includes reductions in referrals to psychological support services. Reductions in antidepressant prescribing are also emerging.

Levels of evidence are sufficient to identify Awhi Ora's direct contribution to improved mental health and well-being outcomes for people accessing support, increasing access for Māori, Pacific and youth, and value for the primary care and other sector partners who introduce people to Awhi Ora. The preventative nature of Awhi Ora and its unified role in meeting social needs, providing support in people's homes and in their communities, infers a strong contribution to system benefits that will be realised beyond the health sector.

The growing evidence is that such initiatives provide a greater number of tools for general practice and help manage patient demand while improving patient wellbeing.

The above programmes have directly funded the new roles such as the Health Improvement Practitioners and the Health Coaches. However, general practices did not require additional funding when referring patients to Awhi Ora.

174. What are the likely DHB costs of proposed cheaper GP visits and increased primary care mental health access on increased DHB utilization and mental health pharmaceutical spending?

Response to Question 174

It is uncertain as to how the changes will impact on demand. Demand will also be influenced by how quickly eligible patients will obtain a community services card. The response to Question 173 shows that with good community mental health services in place and new roles such as the Health Improvement Practitioners and Health Coaches demand at the general practice can be managed and pharmaceutical use may not necessarily increase.

175. Is primary care adversely effected by delays to the GP funding review?

Response to Question 175

General Practice Funding has had the benefit of annual reviews via the PSSAP process including annual uplift in capitation rates. Such process and annual uplifts have not occurred in all parts of the Health and Disability sector. Thus, while the funding review is delayed general practice funding is no worse than and often better than other parts of the Health and Disability sector.

176. Does the DHB expect after hours GPs to be registered with a specialist urgent care college?

Response to Question 176

Auckland DHB has funded reduced costs of after-hours care for patients over 65 years of age, or who hold a Community Services Card (CSC), or High User Health Card (HUHC), or have been identified as living at a quintile 5 address. Contracts with a select number of Urgent Care Clinics that provide after-hours services seven days per week from 5 – 8 pm and a smaller number that continue to be open through to 8 am. Both DHBs require Doctors in these Urgent Care Clinics to be registered with the Royal NZ College of Urgent Care.

A number of other practices open extended hours and there is no requirement for them to be registered with the Royal NZ College of Urgent Care.

177. What 3 policy changes would have been most impactful for GPs in the past year, listed by policy, impact and cost?

Response to Question 177

Assuming this question refers to national policy changes, the most impactful policy change will have been the decision to reduce fees for those with a Community Services Card (CSC). We understand that many people entitled to a CSC do not have one. Thus the true impact will be seen over time as more eligible people obtain a CSC. Areas of the DHB where there are either high proportions of low income families or elderly are likely to be where GPs see the most impact. Cost is one significant barrier to many people accessing primary care. This decision will lower this barrier and has the potential to improve access to care, and associated morbidity and mortality, once implemented on 1 December 2018.

Secondly, the change to free under 14s rather than under 13s will have some impact. However, the numbers of eligible people is relatively small for what in general is a healthy age group.

Both the aforementioned policies are funded through new funding so cost to the DHB is covered. Until we know the change in demand for primary care services as a result the costs and associated funding are best estimates.

Thirdly, the implementation of the national Systems Level Measures Quality Improvement framework has had a significant impact. Although this has been going for over a year, we have found that over the last year this framework has become business as usual for primary care, and the development of a regional Improvement Plan (with three DHBs and seven PHOs) has resulted in a highly collaborative environment where PHOs and practices can share best practice. This is particularly impactful as all parts of the health sector, not just primary care, are required to work together under this plan. This has resulted in a never seen before focus on integration and the patient journey across the system. The funding associated with this framework has supported primary care to utilise quality improvement tools (such as Plan Do Study Act cycles) to improve quality of care.

178. Do GPs in the DHB area “generally” suffer from workloads that are unsafe or unhealthy?

Response to Question 178

Auckland DHB is unable to comment on GP workloads.

179. Are GPs appropriately remunerated?

Response to Question 179

GPs receive funding from a wide variety of sources. Auckland DHB does not collect information on GP remuneration and are not able to comment on whether the remuneration GPs receive is appropriate.

180. How many PHOs have service arrangements in the DHB area listed by PHO and main contact number?

Response to Question 180

Auckland and Waitemata DHBs operate a joint District Alliance. We have six PHOs with service arrangements across Auckland DHB and Waitemata DHB.

PHO	Contact Number	DHB area
Auckland PHO	09 3794022	Auckland
ProCare	09 3777827	Auckland & Waitemata
Alliance Health Plus	09 5884260	Auckland
National Hauora Coalition	09 9503325	Auckland
Comprehensive Care PHO	09 4151091	Waitemata

Total Healthcare (a Counties Manukau DHB based PHO) has service arrangements via ProCare in both Auckland DHB and Waitemata DHB areas.

181. How is the DHB incentivising/encouraging a shift of services and funding to primary care? Ask an example, will DHBs be encouraged to devolve services like skin cancer excisions away from hospitals and into primary care?

Response to Question 181

The DHB has a couple of mechanisms by which it supports the shift of services to the primary care setting. The first is through the Primary Options for Acute Care (POAC). While this was set up initially as a mechanism for to prevent acute admission, it has more recently become a mechanism for funding non acute services e.g. care for patients requiring opioid substitution treatment in the primary care setting has been made available through POAC. Secondly, through the Rural Alliance we are developing and implementing initiatives designed to support expanded patient care through general practice. Additionally, some services are collaborative arrangements between the DHB services and general practice, such as minor skin lesion service. Under the minor skin lesion service which has been in place now with General Practice for several years, the DHB triages and manages bookings and general practices are contracted to do the skin lesion removals.

Auckland DHB's investment in POAC to fund a number of services in primary care which historically would have been provided by secondary care is approximately \$1.8 million per annum. This funds general practices to undertake actions to avoid an ED attendance across a range of investigations, care and treatment and represents approximately 6500 packages of care in the Auckland DHB region. An external evaluation suggested that since its implementation POAC has contributed to a significant reduction in acute demand. This aligns with the Northern Region Long Term LTIP objectives regarding increasing the level of care provided in the community to reduce hospital admissions and length of stay. We continue to grow the number of services provided under this contract in primary care (for example, adding funding for Long Term Reversible Contraception) and anticipate this will only increase as we shift services to primary care.

182. How are GPs to be compensated for the time and costs associated with providing coronial reporting?

Response to Question 182

Auckland DHB does not pay GPs to be involved in coronial reporting.

183. What new workforce roles could be developed in general practice to assist general practice?

Response to Question 183

We are exploring the impact of new primary care roles such as Health Coaches and Health Improvement Practitioners. Such roles have been tested in the primary mental health setting and are soon to be tested with diabetes care in general practice. Health Coaches/Health Improvement Practitioners can range from a peer or lay person to registered health professionals and as part of the general practice team work collaboratively with patients and families to:

- Support self-management;
- Bridge any gaps between clinicians and patients ;
- Navigate through the health care system;
- Provide emotional support;
- Motivate behaviour change through a structured support partnership, and
- Provide continuity of care.

184. How might the current scope of practice of general practice team members (including new roles) be changed to meet the challenges of primary care in the future ?

Response to Question 184

Increasing the skills of the general practice teams to support both the range of services and improved access to services for patients will be a key to improved care. Increasing the numbers of nurse practitioners, nurse prescribers and nurse specialists is a priority. General practitioner skill development so they can pick up services currently provided by the DHB services is also a priority. These expanded roles will need to be located in general practice facilities with the appropriate physical capacity and fit out to enable effective delivery.

Home visiting by general practice would have a positive impact on the care of patients.

185. How many GP practices qualify as rural and what is this as a proportion of all GPs?

Response to Question 185

Rural Practice Numbers ⁺	Total Practice Numbers	% of Practice Rural
5	140	4%

186. What is the age profile of GPs in rural practices?

Response to Question 186

Auckland DHB does not collect data on the age of the GP workforce. Please refer to the Royal New Zealand College of General Practitioners workforce survey.

187. What is the average practice population of GPs in rural practices?

Response to Question 187

2251

The above is averaged by the number of practices who have separate patient registers - 5 in ADHB.

Data Source - PHO Capitation Report Interactive Oct to Dec 2018

188. How is rural mental health assessed?

Response to Question 188

Auckland DHB and Waitemata DHB undertook a mental health needs assessment that has informed our priorities for mental health service development. While this assessment did not have a particular focus on rural mental health the findings are equally applicable.

In Auckland DHB we undertook a Needs Assessment for Waiheke Island, a community in the Hauraki Gulf. Mental health was a key focus area. The findings from this needs assessment are being used to inform health service development for our rural communities.

189. Are all rural health facilities connected with fast internet?

Response to Question 189

Auckland DHB does not collect data on the number of rural health facilities connected with fast internet.

190. How much research funding per year is spent on rural health research in the DHB, listed by year?

Response to Question 190

Auckland DHB does not fund any rural health research.

191. Does the DHB support further PBFF adjustments (beyond the current adjusters) for rural practices?

Response to Question 191

Not without clear evidence showing this to be necessary. There is currently a significant adjuster to rural populations overall and there are also unique costs for metropolitan areas not given any adjusters – fuel taxes, higher rents and capital costs, larger number of non-English speaking residents etc. that all add in costs not experienced in more rural areas.

192. Quantify the rural health workforce need in the DHB listed by providers e.g. number of rural GPs required, Practice Nurses etc?

Response to Question 192

Auckland DHB has not formally considered the rural workforce requirements, but it is intended to be a focus of the Auckland DHB and Waitemata DHB Rural Alliance in year two of their work plan.

193. Given the state of rural health in your DHB in the past year, If the DHB had been given \$1M per year of new untagged funding, for 4 years, what rural health initiative(s) would you have advanced and what would be the measurable outcome measures?

Response to Question 193

There are a broad range of health issues facing rural New Zealand and any additional spending would need to be considered in the wider context of funding health care to achieve the highest quality health outcomes.

The Waitemata DHB and Auckland DHB Rural Alliance covers rural general practices domiciled in both Auckland DHB and Waitemata DHB. Question 183 answer has detail of investment already made through the Rural Alliance. Additional funding would allow the Rural Alliance to expedite activities in their work plan to ensure equitable access to services for our rural populations to avoid unnecessary emergency department visits and/or hospitalisations, and facilitate the provision of appropriate care at the right time, in the right place (whether that is at their general practice or by referral to hospital).

The following priorities have been identified:

- Increasing the reach and access to diagnostic services in rural communities including increasing access to x-rays and ultrasounds and investigating the provision and training for clinician performed ultrasounds
- Increasing access to treatments – e.g. Aclasta, Iron infusions, Venesection, Chemotherapy – sharing practice guidelines and increasing competency. Noting a pilot funding Ferinject infusions in rural general practices has been initiated.
- Increasing access to therapeutics – dispensing practices; structure and rules
- Accessing services via Telehealth – e.g. outpatients appointments
- Development of Multi-Disciplinary Teams; Mental Health, Shared Care, Specialists in the Community
- Step Up, Step Down Beds in clinics and rest homes

194. What methamphetamine focused programs were operational in the past financial year?

Response to Question 194

Waitemata DHB provides methamphetamine-specific interventions, from the range of alcohol and drug services provided to the three District Health Board areas in the Auckland region. The services provided include: Community Alcohol and Drug Services (CADS) Counselling Service; CADS Medical Inpatient Detoxification Service (IPU); CADS Community and Home Detoxification Service (CHDS); CADS Auckland Opioid Treatment Service (AOTS - Specialist and GP programme); CADS Dual Diagnosis Service; CADS Youth Service (Altered High); CADS Pregnancy and Parental Service (PPS); WDHB Māori Alcohol and Drugs Services (Te Atea Marino) and WDHB Pacific Island Alcohol and Drugs Services (Tupu). CADS, Te Atea Marino and Tupu's primary aim is to improve the physical and mental health of people who have been affected by alcohol and other drug abuse. The services provide alcohol and drug interventions at a secondary and tertiary service level.

Methamphetamine abuse or dependence may be disclosed during the initial assessment, in which case clients are provided with methamphetamine and IV drug-use specific information. All clients are directed into treatment options that will match their stage of readiness for change. This is provided in 1:1 or group-based interventions. All therapeutic interventions are recovery focused. Counselling

and group interventions include motivational interviewing, cognitive behavioural therapy (CBT), Dialectical Behavioural Therapy (DBT), 12 Step Facilitation, culturally appropriate interventions, peer support, and family-inclusive practice. In addition clients (including those who identify methamphetamine use) have access to medical and mental health interventions or social and practical support services by registered health professionals.

There are eight main service sites throughout the greater Auckland area, and approximately 30 satellite sites. CADS operates one central access telephone line (09 845 1818) for the public and daily "no appointment walk-in" clinics at five major locations (Point Chevalier, Takapuna, Henderson, Kingsland, Manukau). The walk-in clinics provide low-threshold access and staff are required to be competent in assessing methamphetamine abuse or dependence and in providing IV harm-reduction interventions.

195. How many drug and alcohol addiction FTE staff was employed, listed by years for the past 4 years?

Response to Question 195

The regional drug and alcohol service is run by Waitematā DHB.

196. What is the best comparative assessment of meth use in the DHB over the past 4 years listed by year?

Response to Question 196

According to the NZ National Drug Intelligence Bureau (2017) the Ministry of Health estimates that 1.1% of the population aged 16 – 64 will have used methamphetamines in the previous 12 months. The Global Drug Survey estimates that 5% of the adult population will have used methamphetamines in the previous 12 months. The Drug Harm Index considers that 5.5% of all methamphetamine users are dependent and that the remaining 94.5% are casual.

Determining the meth use in the Auckland Region over the past four years would require independent research, however, applying the above estimates to the three DHB populations suggests that between 13,000 and 60,000 people will have used methamphetamine in the previous 12 months, of whom between 722 and 3200 are dependent users (defined as weekly use or more).

In 17/18 CADS, Te Atea Marino and Tupu engaged with 2,170 individuals with a methamphetamine-related diagnosis. This will not represent all individuals engaged with CADS, Te Atea Marino or Tupu who used methamphetamine as not all clients can be diagnosed and clients may under-report intake. The table below shows the number of client treatment episodes with a methamphetamine-related diagnosis for by the services over the previous 4 financial years.

Table: Treatment episodes for clients with methamphetamine-related diagnosis by financial year 2014-2018

Financial year	WDHB, ADHB + CMDHB districts	ADHB district only
14/15	1847	511
15/16	2176	648
16/17	2395	612
17/18	2170	671

The table below shows the number of client treatment episodes with a methamphetamine-related diagnosis compared to all other treatment episodes across the Auckland region. This represents between 11 and 15% of all treatment episodes.

Table: Methamphetamine-related treatment episodes compared to all other treatment episodes across the Auckland region by financial year 2014-2018

Financial year	Methamphetamine-related treatment episodes	All treatment episodes
14/15	1847	18,051
15/16	2176	19,159
16/17	2395	18,902
17/18	2170	17,825

Further information about volume and quantity estimates of methamphetamine use is likely to be available from "*Methamphetamine use in New Zealand*"¹.

NZ National Drug Intelligence Bureau (2017). *Methamphetamine Users in New Zealand (Restricted Document)*.

197. What is the profile (demographic profile) of meth users?

Response to Question 197

Waitemata DHB delivers services for the region for Community Alcohol & Drugs (CADS), not our Mental Health Directorate

198. What meth interventions does the DHB undertake and describe the costs of each intervention and measurable outcomes?

Response to Question 198

WDHB deliver services for the region for Community Alcohol & Drugs (CADS), not our Mental Health Directorate

199. Is the DHB aware of the NDHB joint program with Police "Te Ara Oranga" and would this be suitable for this DHB, if not why not, and if so, what would be required to deploy ?

Response to Question 199

Waitemata DHB delivers services for the region for Community Alcohol & Drugs (CADS), not our Mental Health Directorate

200. What would be the most impactful health portfolio initiative to combat meth use in the DHB?

Response to Question 200

WDHB deliver services for the region for Community Alcohol & Drugs (CADS), not our Mental Health Directorate

201. Given the state of meth use in your DHB in the past year, if the DHB had been given \$1M per year of new untagged funding, for 4 years, what meth initiative(s) would you have advanced and what would be the measurable outcome measures?

Response to Question 201

Methamphetamine

- Methamphetamine use is in the context of broader poly substance use. Therefore we need to treat people in the context of multi-substance use rather than per substance meaning the approach is broad rather than solely methamphetamine. Alcohol is biggest impact in ED for example.
- Prevalence: Methamphetamine related diagnosis (WDHB, ADHB, CMDHB) 2017/18: 2170. This is a proxy for incidence and relates to a treatment seeking group who have been assessed so it is an under-estimate of prevalence but provides a baseline.
- ED, Police and St Johns have high routine contact with people experiencing acute drug harms and associated risks but do not have expertise or easy access to AOD expertise
- Can also leverage off acute drug harm funding that is primarily synthetics specific and link with other initiatives
- The proposed approach, outlined below, is designed to address these needs

Approach

- Peer support is a key element missing from AOD continuum of care
- Co-design approach with service users defining what their needs are and how these can best be met
- Have a highly mobile assertive outreach model that goes to where the need is and accompanies existing providers to call outs/presentations carrying a phone similar to psychiatric line
- Purpose of this approach is to:
 - provide targeted screening and brief interventions
 - provide triage to support hours and treatment services
 - linkages to AOD and MH treatment services
 - Referral to 'Meth and Me' groups that are located in community services (Merge Café, CMHCs, Inpatient units etc.)
- Co-locate 1 x peer and 1x practitioner in 4 sites (in first instance ADHB focus).
 - Police cells (Auckland Central Station)
 - St Johns (Pitt Street)
 - Inpatient unit (TWT)
 - Emergency Department (Auckland Hospital)

Co-location of peer and AOD practitioners break down silos increase education and knowledge of multi-sector providers, increase AOD knowledge, improve interactions with our consumers, decrease stigma, improve health and social outcomes, provide holistic care – address for people Maslow's hierarchy of needs. This could also support NGOs working with homeless request for clinical support services.

Workforce and estimated cost \$1.1M per annum – health and harm reduction approach

- 4 AOD Practitioners (1 per site) \$120k = \$480 k
- 4 peer support workers (1 per site) \$105k x4 = \$420k (providing support hours model) could do via number of hours (alternatively)
- \$100k Backbone function co-ordination management of support hours, triage, management of multi-sector work

- \$100k Flexi fund (address high support needs)

Evidence base

The current *Odyssey* model, funded by Corrections and based in Mt Eden prison, provides assessment and brief intervention to people who are then referred to a 'Meth and Me' group. The proposed approach is a community based expansion of this group model.

- Services provided by NGO employed workforce, both practitioners and peer workforce, to be located in existing DHB and multi-sector agencies for the prototype. Ultimately, if this is effective, partner agencies could be approached re: co-funding of positions and expanding the focus (e.g. ACC, MSD, Probation)
- Kaupapa service – to determine location preferred – Marae based or other hub
- Open door approach access treatment from multiple community based sites

Justification

Peer support is:

- Effective in increasing engagement and retention in treatment
- Provided by faces they "trust"
- Workforce support by expert peer leads break down stigma
- Expertise from health practitioners to support access to DHB services, credibility etc.
- Provides employment and training opportunities for people who have completed treatment services

Multi-sector focus

Partner agencies and parts of service are providing front line AOD support without necessary expertise. Providing peer and specialist AOD assessment, brief interventions and linkages with treatment services and onsite groups (i.e. at inpatient unit) will support people at crisis points or while in existing treatment services (potentially reducing behaviours of concern in ED and inpatient services). Ultimately, if other broader needs are also addressed such as housing, income, connection to whānau, people may not keep representing at crisis points. This is based on the premise that by accessing community hub/existing supports in community sites, this will reduce secondary service utilisation (earlier intervention, closer to home etc. etc.)

Context

There are other services that are developing which can also support this approach i.e. Auckland City Mission Mannaki Wahine and homelessness work. It fits with the inner city collaboration and homelessness work and the Upper Greys Ave development etc.

We need to leverage existing support from services that are tasked with supporting specific groups. Significant proportion of our people have head trauma, cognitive impairment, chronic health conditions, unemployment etc. How can we work with these agencies to best support this group and get them to support via funding i.e. ACC could fund treatment development for those with severe cognitive impairment as a result of a health injury to develop AOD appropriate treatment programme etc.

Similarly we could get MSD to fund employment placements and opportunities to part fund our peer support workers etc. and to provide other opportunities for workforce training and employment opportunities via social enterprise activities (Crisis Café etc.).

\$5M Model social enterprise work and employment and housing

- Could expand to provide more education for specific providers – up skill ED staff, inpatient staff, Police, St Johns and improve their connections to support services
- Provide work and employment and training options
- Provide early intervention and prevention
- Expansion of peer workforce
- Social enterprise
- Expansion of prototyped services as above

Outcome measures

- **RBA** – how much did we do, how well did we do, was anyone better off?
- **Patient experience**
- Number of groups run
- Support hours provided
- Care packages
- Education
- Number of brief interventions
- In-services provided
- Knowledge of AOD by partner agencies – increased knowledge pre-post test
- Reduction in LOS in ED
- Reduction in re-presentations
- Multi-sector partnerships
- Reduction in behaviours of concern in ED and inpatient services

202. What is the total cost of mental health medications, listed by year and major mental health condition categories?

Response to Question 202

Mental Health Category	Sum of Cost for Financial year 2017/2018
Antidepressants	\$6,283.72
Antipsychotics	\$324,502.94
Mood Stabilisers	\$49,709.10
Sleep/Anxiety	\$59,852.45
Grand Total	\$440,348.21

Explanatory notes

1. Data used is pharmacy service billing data which includes both individual patient dispensing and Imprest (medication room) supply. As such it is only an approximation of the medications actually used by patients but is an accurate reflection of the cost.
2. Data is only for medications dispensed to secondary care (inpatients and community mental health centres) within Auckland DHB. We do not have access to primary care data.
3. Drugs included are those with mental health indications. Therefore;

- Medications are included based on indication only not clinical area i.e. antidepressants used in general surgery wards costs are included, laxative medications used in mental health areas are not.
- Nicotine replacement medications have not been included as this is not technically deemed a mental health category but is a major cost to mental health services at ADHB. This is reported separately to the Mental Health directorate as part of routine expenditure reports. The Mental Health directorate spends approximately \$2500 per three months on nicotine medication.
- This cost includes medications that have both mental health indications and non-mental health indications e.g. sodium valproate is a major percentage of mood stabilisers category but this medication can be used for both mood stabilisation (mental health indication) and seizure management/prevention and epilepsy control (neurological indication). We have no mechanism for separating this cost.
- There is no standardised categorisation used. Our mental health specialist pharmacists have suggested categories based on their experience and the New Zealand Formulary headings. This is specified in the following appendix.

Appendix 1: Mental Health Categories used.

Substance name	Category
Citalopram	Antidepressants
Escitalopram	Antidepressants
Fluoxetine	Antidepressants
Fluvoxamine	Antidepressants
Paroxetine	Antidepressants
Sertraline	Antidepressants
Amitriptyline	Antidepressants
Clomipramine	Antidepressants
Dosulepin	Antidepressants
Doxepin	Antidepressants
Imipramine	Antidepressants
Nortriptyline	Antidepressants
Trimipramine	Antidepressants
Maprotiline	Antidepressants
Phenelzine	Antidepressants
Tranylcypromine	Antidepressants
Moclobemide	Antidepressants
Mirtazapine	Antidepressants
Venlafaxine	Antidepressants

Bupropion	Antidepressants
Reboxetine	Antidepressants
Amisulpride	Antipsychotics
Aripiprazole	Antipsychotics
Clozapine	Antipsychotics
Olanzapine	Antipsychotics
Olanzapine pamoate	Antipsychotics
Paliperidone palmitate	Antipsychotics
Quetiapine	Antipsychotics
Risperidone	Antipsychotics
Ziprasidone	Antipsychotics
Chlorpromazine	Antipsychotics
Haloperidol	Antipsychotics
Haloperidol decanoate	Antipsychotics
Pericyazine	Antipsychotics
Pimozide	Antipsychotics
Prochlorperazine	Antipsychotics
Trifluoperazine	Antipsychotics
Zuclopentixol	Antipsychotics
Zuclopentixol acetate	Antipsychotics
Zuclopentixol decanoate	Antipsychotics
Flupentixol decanoate	Antipsychotics
Fluphenazine decanoate	Antipsychotics
Carbamazepine	Mood Stabilisers
Lithium	Mood Stabilisers
Sodium valproate	Mood Stabilisers
Lamotrigine	Mood Stabilisers
Lorazepam	Sleep/Anxiety
Diazepam	Sleep/Anxiety
Clonazepam	Sleep/Anxiety
Oxazepam	Sleep/Anxiety
Zopiclone	Sleep/Anxiety

Melatonin	Sleep/Anxiety
Temazepam	Sleep/Anxiety
Nitrazepam	Sleep/Anxiety

203. What is the average recruitment time for a. drug and alcohol addiction specialists and b. drug and alcohol addiction nurses, listed by year for the past 4 years?

Response to Question 203

WDHB deliver services for the region for Community Alcohol & Drugs (CADS), not our Mental Health Directorate

204. How many vacancies are there for a. drug and alcohol addiction specialists and b. drug and alcohol addiction nurses, listed by year for the past 4 years?

Response to Question 204

WDHB deliver services for the region for Community Alcohol & Drugs (CADS), not our Mental Health Directorate

205. How many inpatient drug and alcohol addiction beds does the DHB have on average per year, listed by year for the past 4 years, and what is the cost of those beds per year ?

Response to Question 205

Auckland DHB does not have any inpatient drug and alcohol beds as the service is a regional service provided by Waitemata DHB.

206. How many outpatient drug and alcohol addiction beds are there per year, listed by year, organisation, and beds available for the past 4 years and what are the costs of those beds ?

Response to Question 206

We do not contract “outpatient” drug and alcohol addiction beds specifically, however, across the Auckland region NGO providers operate residential drug and alcohol beds. Waitemata and Auckland DHBs hold contracts for a total of 206 beds across the following six NGO providers:

- Auckland City Mission
- Connect
- Higher Ground
- Odyssey
- Salvation Army
- Wings Trust.

The bed numbers have remained stable over the past four years and with the exception of Connect Services, who only provide services to Waitemata residents, these beds are available to residents from across the Auckland region.

The contracted value of these beds over the past four years is:

14/15	15/16	16/17	17/18
\$9,466,868	\$9,538,099	\$9,607,148	\$10,275,583

207. How much money is spent on NGO drug and alcohol services listed by year, NGO providers, nature of service provision and funding per organisation for the past 4 years?

Response to Question 207

In addition to the contracted NGO residential drug and alcohol beds referred to in the above question, Waitemata and Auckland DHBs also hold contracts for community, non-bed based drug and alcohol services. These services provide assessment, counselling and home detoxification for residents across the metro Auckland region and are held across the following NGOs:

- Te Whanau O Waipareira Trust
- Te Runanga o Ngati Whatua
- Piritahi Hau Ora Trust
- TRANX (14/15 only)

The total additional spend on these services:

14/15	15/16	16/17	17/18
\$1,291,551	\$889,645	\$898,542	\$914,716

Please note that TRANX exited their contract, in the 14/15 year and this work was subsequently absorbed by the Waitemata DHB regional CADS service.

In addition to the locally contracted beds we purchase NHI based beds from Nova Trust in Christchurch for limited periods of time when there is a particular individual need. The cost of these beds over the past four years are below:

14/15	15/16	16/17	17/18
\$8,376	\$9,871	\$ 18,200	Nil

208. Does the organisation believe Direct To Consumer Advertising (DTC) in New Zealand is an effective use of health dollars and if so, why?

Response to Question 208

Auckland DHB has not developed a specific position on DTC. Additionally the DHB does not spend any of its allocated Vote Health spend to this area.

We do support approaches that reduce barriers to the effective use of pharmaceuticals. Patients with complex medication regimens usually require consistent and regular support and as such we would anticipate that DTC, by and in of itself, being able to necessarily improve patient use of pharmaceuticals.

209. Given the choice of health dollars being spent on DTC television and media advertisements or cheaper pharmaceuticals, which advocacy position does the organisation support?

Response to Question 209

We support the removal of barriers to access to care. Reducing cost is an important barrier so access to cheaper pharmaceuticals would be welcome. However, cheaper medications alone without patients taking their medications appropriately will not necessarily result in improved health outcomes. Thus, the DHB supports approaches that both improve access to and patient and whanau support and understanding in the appropriate use of pharmaceuticals.

210. Do you think patients in your DHB would prefer DTC television and media advertisements or cheaper pharmaceuticals?

Response to Question 210

We have not canvassed or consulted with patients so we are unable to provide any substantiated response to this question. We would assume patients would prefer access to cheaper pharmaceuticals.

211. What is the general position of prescribing doctors within the DHB on the benefits or otherwise of DTC?

Response to Question 211

We have not canvassed or consulted with doctors within the DHB or in primary care so we are unable to provide any substantiated response to this question.

212. One argument against DTC is that it places false expectations on patients. Is this an observation that is supported across the organisation?

Response to Question 212

We have not canvassed or consulted with patients and or doctors so we are unable to provide any substantiated response to this question.

213. One argument against DTC is that it places undue pressure on prescribers to prescribe what the media is presenting to them. Is this an observation that is supported across the organisation?

Response to Question 213

We have not canvassed or consulted with doctors within the DHB or in primary care so we are unable to provide any substantiated response to this question.

214. One argument for DTC is that it provides meaningful consumer information and consumer choice. Is this an observation that is supported across the organisation?

Response to Question 214

We have not canvassed or consulted with patients and or doctors so we are unable to provide any substantiated response to this question. Our experience is that medication management and getting patient understanding of appropriate use is complex and is not achievable without consistent and regular support. Thus, we do not see DTC, by and of itself, being able to necessarily improve patient use of pharmaceuticals.

215. Do you have an implementation plan to action your regional disability strategy, if so, what is that plan?

Response to Question 215

Auckland and Waitemata DHBs have a joint NZ Disability Strategy Implementation Plan 2016-2026. The link is below. We are currently working with Counties Manukau DHB to create a regional Implementation Plan.

<http://www.waitematadhb.govt.nz/dhb-planning/organisation-wide-planning/disability-strategy/>

216. Do you have baseline data to measure:

- a) That disabled people are getting appropriate treatment
- b)The number of people with disabilities that you employ
If so, what is that data listed by year over the past 4 years ?

Response to Question 216

- a) That disabled people are getting appropriate treatment

We are aware adequate data on disabled people is lacking. We do not have baseline data to show disabled people are getting appropriate treatment

- b) The number of employees who have disclosed a disability over the past four years are included in the table below;

Year ending	# of people that disclosed they have a disability
30/06/2015	33
30/06/2016	32
30/06/2017	32
30/06/2018	30

217. Do you have targets to ensure:

- a) That disabled people are getting appropriate treatment
- b) The number of people with disabilities that you employ
If so, what are those targets?

Response to Question 217

While Auckland DHB does not have a set employment target, we have recently been awarded the Accessibility Tick. The Accessibility Tick Programme guides and supports an organizations commitment to accessibility and disability inclusion, by making meaningful steps towards becoming more accessible and inclusive. This is achieved and measured by completing nine accessibility competencies.

We have completed a gap analysis and with recommendations made by Access Advisors, we have developed an action plan.

Our Accessibility Tick action plan will guide us in demonstrating an active, consultative commitment to all areas of accessibility and inclusion. In the first 12 months we will be focused on:

- Developing a fully accessible recruitment process that enables diversity, reaches qualified applicants with access needs and reduces the likelihood of disability discrimination in hiring, and therefore increase the number of employees with an accessibility need.
- Ensuring internal and external communications and marketing are accessible and inclusive of people with disabilities.
- Striving to ensure Information and Communications Technology (ICT) is accessible to people with disability needs.
- Encouraging suppliers and partners to mirror our commitment to accessibility and inclusion

218. What programs or initiatives do you have to ensure:

- a) That disabled people are getting appropriate treatment
- b) The number of people with disabilities that you employ?

Response to Question 218

There is no single program or initiative that ensures disabled people are getting appropriate treatment.

Disabled people should be able to access the health services they need when they need them.

Different services will be more important than others at different life stages as the same as the general population.

Auckland DHB has not historically captured disability status from employees. We have recently been awarded the Accessibility Tick and as part of our action plan for 2019 we will run a campaign to update our records.

219. Who is the champion for disability issues in your DHB and on the DHB board?

Response to Question 219

Sue Waters, Chief Health Professions Officer, is the Executive Disability Lead for Auckland DHB and reports to the Chief Executive Officer. Members of the Board that sit on the DiSAC are the Champions at Board level:

- Jo Agnew
- Michelle Atkinson
- Robyn Northey

220. What proportion of total DHB funding was allocated to disability services in each of the last 4 financial years?

Response to Question 220

Disability services are funded directly by the Ministry of Health. Auckland and Waitemata DHB does not currently hold contracts for disability services.

221. How many disability related complaints has the DHB had in each of the last 4 financial years?

Response to Question 221

Auckland DHB is unable to provide a specific answer to this question. A complaint received by the Auckland DHB is logged into our central complaints system and categorised against a set criteria

based on the issues raised in the complaint. Auckland DHB does not have a category related specifically to disability, but has broad categories of issues such as: Diagnosis, Communication Style, arrangement for discharge etc.

Auckland DHB notes that the issues which we categorise against could be encountered by any patient or family/whānau member with or without a disability. Furthermore when the patients details are recorded Auckland DHB does not record whether the patient has a disability or not and we respond to each complaint in an individualised manner to answer the concerns raised in each complaint.

However, Auckland DHB does have one category to capture the number of complaints we receive in regards to the 'number of available disability parking spaces' A breakdown of complaints relating to this subject is outlined below:

Financial year	Number of complaints
2014/2015	1
2015/2016	1
2016/2017	2
2017/2018	1

222. What is the single most important health portfolio issue affecting disabled people today?

Response to Question 222

There is no one single health portfolio that affects all disabled people. Disabled people should be able to access the health services that they need, when they need them. Different portfolios will be more important than others at different life stages, the same as the general population.

223. Which key stakeholders does the DHB approach as representatives of the disabled community listed by name?

Response to Question 223

Auckland DHB has an accessibility group which meets regularly, and focuses on health issues for disabled people.

The members of the Auckland DHB Accessibility group are:

- Mary Schnackenberg
- Samuel Cho
- Ezekiel Robson
- Rodney Beale
- Gabrielle Hogg
- Vivian Naylor

There are other members of staff within the Auckland DHB who also oversee various aspects relating to the disability community, these people are:

- Sandy Grant

- Justin Kennedy-Good
- Abbi Harwood-Tobin
- Rachel Lorimer
- Suzanne Corcoran

Vivian Naylor, CCS Disability gives advice on buildings and facilities projects, as required to both WDHB and ADHB.

There are also a number of people that the Disability Advisor contacts on an Ad hoc basis depending on the project or work being done.

224. List the NGO disability providers providing disability services listed by name, nature of service and contact details

Response to Question 224

Disability services are funded directly by the Ministry of Health. Auckland DHB does not currently hold contracts for disability services.

225. What interpretation service (type of service, access and availability) does the DHB provide for deaf or hearing impaired people?

Response to Question 225

We provide a 24/7 interpreting service for the deaf or hearing impaired community. Face-to-Face interpreting and appointment confirmations are the most common types of services but we can also provide translations. The only service that is not available for Sign Language is Telephone Interpreting.

226. How much is budgeted for sign language interpreters, listed by year for the past 4 years?

Response to Question 226

We don't budget separately for sign language as it is part of the overall interpreting services budget.

227. How much has been spent on sign language interpreters per year, listed by year for the past 4 years?

Response to Question 227

Demonstrated in the table below is the spend over the last four years:

2014/2015	\$137,786.39
2015/2016	\$90,631.15
2016/2017	\$94,478.70
2017/2018	\$133,901.59
2018 Year to date to October	\$48,513.20
Total	\$505,311.03

228. How many cochlear implants have been funded per year, listed by year over the past 4 years?

Response to Question 228

The MOH contracts directly with NGO providers for Cochlear Implant services. There is no DHB contract so the DHB is not able to answer these questions.

229. How many people are on the waiting list for cochlear implants, listed by year for the past 4 years?

Response to Question 229

The MOH contracts directly with NGO providers for Cochlear Implant services. There is no DHB contract so the DHB is not able to answer these questions.

230. Does the DHB perform cochlear implants and if so at what cost and if not then who undertakes this and at what cost?

Response to Question 230

The MOH contracts directly with NGO providers for Cochlear Implant services. There is no DHB contract so the DHB is not able to answer these questions.

231. How long is the waiting list for cochlear implants, listed by year for the past 4 years?

Response to Question 231

The MOH contracts directly with NGO providers for Cochlear Implant services. There is no DHB contract so the DHB is not able to answer these questions.

232. What mobility access initiatives has the organisation undertaken for disabled people within the organisation and within the community?

Response to Question 232

Level 5 refurbishment (Carpark A entry) was co-designed with an accessibility group representing a range of needs/perspectives. The final design, completed 2017, has a particular emphasis on cognitive impairment, alongside functional impairment. This can be seen in the very simple palette, an attempt to minimise visual noise, reconfiguration (to make the path through easier to see) and introduction of natural light and views to outside, to help people get their bearings.

233. Does the organisation support more robust and community pervasive mobility access legislation for disabled people and if so, what actions have they undertaken to support this ?

Response to Question 233

We haven't formally canvassed the DHB about supporting a more robust review of the legislation and are therefore unable to provide comment. We are very committed to increased accessibility and our focus has been on achieving the Accessibility Tick and other actions as outlined in our Disability Action Plan for 2019-2022.

234. What is the single most impactful health portfolio issue affecting disabled people today?

Response to Question 234

There is no one single health portfolio that affects all disabled people. Disabled people should be able to access the health services that they need, when they need them. Different portfolios will be more important than others at different life stages, the same as the general population.

235. How many data breaches has the organization had in the past financial year?

Response to Question 235

healthAlliance reported zero data breaches in FY2017/18.

236. Does the organization have a data security policy in the past financial year?

Response to Question 236

Yes, the Information Privacy and Security policy covers data security.

Question 236 – Appendix 1

237. Does the organization have a date breach policy in the past financial year?

Response to Question 237

Yes, the Information Privacy and Security policy covers data breaches.

Question 237 – Appendix 1

238. Does the organization have a USB/Ext hard drive inc. CD and DVD/Media card data policy in the past financial year?

Response to Question 238

Yes, the Information Privacy and Security policy covers the use of USBs and other removable storage devices.

239. Does the organization have a data backup policy in the past financial year?

Response to Question 239

Yes, Auckland DHB has a data backup policy in place to ensure recovery outcomes across different technology platforms are aligned and meet business requirements.

240. Does the organization have a data recovery policy in the past financial year?

Response to Question 240

Data recovery is covered within the framework of the IS Disaster Recovery Policy. healthAlliance provides website services as the DHB's IT shared service provider, including day-to-day back-up and restoration of data, E.g. lost or deleted files or emails and database back-ups.

241. Does the organization have a bring your own device policy in the past financial year?

Response to Question 241

Yes, the Mobile Device policy covers bring your own devices

Question 241 – Appendix 1

242. Does the organization have a data cyber security policy in the past financial year?

Response to Question 242

In line with CERT NZ and National Institute for Standards and Technology* guidelines, DHB network passwords are not required to be changed, except in the following instances:

- Where a new user has been set up with a temporary log on password and is required to choose their own unique password after logging on for the first time
 - Where a password has been suspected or known to have been disclosed to unauthorised parties
- In both cases, users must follow the regional password standard when selecting a new password e.g. minimum length and character complexity.

*NIST guidelines often become the foundation for best practice recommendations across the security industry and are incorporated into other standards including NZISM.

243. Does the organization have an encryption, de-identification, encryption or anonymization policy in the past financial year?

Response to Question 243

Auckland DHB takes all appropriate security measures to protect information dependent on context and risk. Auckland DHB's Information Privacy and Security Policy contains statements with regards to the safe and secure handling of data in numerous contexts including the use of encryption, de-identification or anonymization techniques.

Questions 243 – Appendix 1

244. How often does the organization require user passwords to be changed in the past financial year?

Response to Question 244

In line with CERT NZ and NIST* guidelines, DHB network passwords are not required to be changed, except in the following instances:

- Where a new user has been set up with a temporary log on password and is required to choose their own unique password after logging on for the first time
- Where a password has been suspected, or known, to have been disclosed to unauthorised parties

In both cases, users must follow the regional password standard when selecting a new password e.g. minimum length and character complexity.

*NIST guidelines often become the foundation for best practice recommendations across the security industry and are incorporated into other standards including NZISM.

245. Is identity theft cover for data breach affected individuals part of the data breach policy in the past financial year?

Response to Question 245

We do not have any policy statements that refer specifically to identity theft.

246. What information systems, by name and department, are used in the main campus hospital in the past financial year?

Response to Question 246

Auckland DHB has 1595 information system applications and 98 are critical/key applications. The largest number of applications relate to patient administration (40), followed by diagnostic results (14), and radiology (11). The majority of these applications are used across multiple departments in the hospital.

Critical/key applications are listed in [Question 246 – Appendix 1](#)

247. When was the last time that a successful full data recovery was achieved in the past financial year?

Response to Question 247

There has been no requirement for full data recovery in the 2017/2018 financial year.

248. What is the average number of potential cyber intrusions per week, in the past financial year, that have been stopped at the organisations IT cyber security perimeter such as the organisations firewall?

Response to Question 248

healthAlliance blocked an average of 36,734 potential cyber intrusions per week at its cyber security perimeter (firewall) for all four Northern DHBs in the last financial year.

249. How many cyber security breaches has the organization had in the past financial year?

Response to Question 249

Of the 27,000 staff across the four Northern DHBs, healthAlliance reported 61 breached webmail accounts in the last financial year.

healthAlliance has proactive 24/7/365 monitoring systems in place for the region and compromised accounts are automatically blocked from sending email when a security threshold is passed. An investigation is then carried out and password resets enforced.

Users are also required to retake phishing email awareness training to prevent recurrence of their credentials being stolen. Two factor authentication is currently being implemented for Outlook webmail to close this vulnerability.

250. Which NGOs during the past financial year have shared client level data with the DHB?

Response to Question 250

The following NGOs have shared client level data with us via the Regional Shared Care Platform:

- Enliven

- Lifewise

The following NGOs are able to view client level data from the DHB for NGO community patients only:

- Royal District Nursing Service
- Enliven
- Waiheke TrustLifewise
- Healthcare NZ

251. What is the average availability (uptime as a percentage of time) that the main patient electronic health record has been available in campuses that have the HER in the past financial year?

Response to Question 251

The average availability of the main patient electronic health record in the past financial year was 99.98%

252. What is the average availability (uptime as a percentage of time) that the internet has been available across all campuses in the past financial year?

Response to Question 252

The average internet availability in the past financial year was 99.99%

253. What is the average availability (uptime as a percentage of time) that the in-house IT network has been available across all campuses in the past financial year?

Response to Question 253

The average availability of the IT network in the past financial year was 99.95%

254. What is the average network speed for data across all campuses in the past financial year?

Response to Question 254

In campus sites across Auckland DHB, the aggregated average network speed between WAN (Wide Area Network) links over the last 12 months has been 1.23Gbps downlink (19.42Gbps peak) and 1.26Gbps uplink (18.45Gbps peak).

255. What is the average internet speed across all campuses in the past financial year?

Response to Question 255

Campus sites across Auckland DHB share an internet resource with a combined aggregated average speed of approximately 62.35Mbps downlink and 4.82Mbps uplink of internet traffic over the last 12 months.

256. How many people are employed in information and communication technology services in the past financial year?

Response to Question 256

The IS Services Headcount as on 30 June 2018 was 62.

257. How many people per capita (DHB population) are employed in information and communication technology services in the past financial year?

Response to Question 257

Auckland District Health Board serves a population of approximately 521,945 people.

People per capita is $62/521945 = 0.000118 = 0.012\%$

258. How many people per total organizational head count are employed in information and communication technology services in the past financial year?

Response to Question 258

Total Auckland DHB organisational Headcount as on 30 June 2018 is 10,796.

People per total organisational headcount is $62/10796 = 0.005 = 0.57\%$

i.e. the Information and Communication Technology Service contributed to 0.6% of the total ADHB headcount in the past financial year (ending 30th June 2018)

259. How many email messages were transmitted across the organizational network in the past financial year?

Response to Question 259

healthAlliance (as the shared IT service provider for the four Northern Region DHBs) manages a combined email system for the region. In total there were:

* 36,564,548 external emails sent regionally (from all 4 DHBs)

* 207,000,000 internal emails sent regionally (from all 4 DHBs)

260. What is the slowest component of the ICT system in the past financial year?

Response to Question 260

The slowest component of the ICT system in the past financial year is Soprano Medical Templates (SMT). SMT is used by clinical staff for creating discharge and other clinical documents. The current version is nearing the end of its life and running on old databases. SMT will be upgraded when the DHB migrates from Concerto to Clinical Portal 8, which is planned for implementation in mid-2020. This will help to alleviate performance issues.

261. Is the organizational compliant with all software licensing requirements in the past financial year?

Response to Question 261

healthAlliance manages software licensing for Auckland DHB (as the shared IT service provider for the four Northern Region DHBs). healthAlliance conducts a range of activities to ensure compliance with software licensing requirements. For example:

- Microsoft end-user and Microsoft platform software is covered under the Government G2015 Microsoft Enterprise Agreement, which has an annual 'True Up' process. In preparation for this, healthAlliance conducts compliance audits to licence schedules. The

region is in the process of negotiating and gaining approval for a new Microsoft contract. The new agreement is expected to include provisions for maintaining the region's Microsoft licence compliance obligations.

- Other non-Microsoft platform and infrastructure licences are regularly reviewed with vendors to ensure compliance and the purchase of any additional licences as required i.e. Oracle, IBM SAN licences, Cisco Management Suite or Citrix.
- healthAlliance has a managed desktop environment that tightly controls deployment of licenced software.

Application software is covered by either platform, enterprise, environment or named user licensing. Regular reviews are undertaken and license compliance is part of the architecture governance review process for any application upgrades.

262. How many people have admin or root access to the main organizational computer system in the past financial year?

Response to Question 262

Of the 27,000 staff across the four Northern DHBs there are 385 people with secure admin access. This is restricted to ICT-related personnel only and is dependent on their access requirements. healthAlliance monitors admin accounts constantly. Alerts are received if anyone creates or updates an admin account. These alerts are cross-referenced to an approved service request. Audits of administrative access are carried out quarterly by the regional IT partner healthAlliance.

263. Does the organization have a white list or black list software application approval policy, and has this been in place in the past financial year?

Response to Question 263

The Northern Region has approved policies that define the standards in what software can be connected to the regional network. In addition there are regional cyber-security and project-related forums that must approve any new software prior to it entering onto the region's network.

The region has an approved blacklist policy (established in 2015) for external web-based applications and specific criteria to guide the Northern DHBs on when to blacklist.

264. How many hours on average are staff educated on organisational cyber security safety in the past financial year?

Response to Question 264

Frontline staff were formally educated on organisational cyber security safety for approximately 20-30mins in the past financial year, along with additional informal education throughout the year.

Formal education consisted of organisation-wide phishing awareness testing which runs monthly. Targeted training is provided to staff, with tips and techniques to avoiding falling victim to phishing emails and other online scams.

Informal education consists of regularly advising staff through newsletters, the intranet and IS Service Desk notifications about online dangers or scams and the steps they can take to keep themselves safe and protect our information and systems.

Additionally, senior DHB managers and executives were provided with cyber security safety education for approximately four hours in the past financial year. This came in the form of a major cyber incident response exercise. This was a regional simulation exercise involving the four Northern DHBs, healthAlliance and observers from the Ministry of Health.

The DHB also supports national cyber security awareness initiatives such as Cyber Smart Week, which provides another useful channel to educate staff about safe cyber security practices.

The region's shared IT service provider, healthAlliance, is committed to raising awareness about cyber security among DHB staff. It was named as a finalist in the 2018 New Zealand Information Security Awards (iSANZ) Best Security Awareness Campaign category for its '*Northern Region DHB Cyber Safety Campaign*', which was highly commended by the judges.

265. What cyber security training do all new employees receive in a financial year?

Response to Question 265

New employees receive the same cyber security training that all employees receive to help keep themselves and the organisation safe from scams or hackers.

This includes online training modules that provide staff with tips and techniques to avoid falling victim to phishing emails and other online scams.

Training also consists of regular notifications via newsletters, intranet and IS Service Desk emails about online dangers or scams and the steps employees can take to protect themselves and keep our information systems safe.

266. Does the organization have an emergency electricity backup system for IT systems and if so what are those mechanisms, how quickly do they respond and how long can they maintain critical IT functions?

Response to Question 266

The Northern region shared IT service provider healthAlliance maintains Uninterruptible Power Source (UPS) backup systems to all critical IT equipment housed within Auckland DHB's data centres.

UPS systems provide electrical protection and continuous changeover to emergency power in the event of a power outage.

The UPS systems are designed with enough capacity to provide a minimum runtime of 20 minutes to maintain critical systems and provide power during the time it takes for the backup generators to start-up. They have full redundancy in place, meaning that if one fails, a back-up kicks in. The UPS systems are monitored and undergo regular maintenance checks and load tests every six months.

Power supplied to the Data Centres is the responsibility of the DHB Facilities department. All main power feeds to the Data Centres are configured with emergency back-up generators. In the event of a power outage, generators automatically start providing power to the room and will change back to mains power once power is restored. DHB Facilities conduct regular generator tests and maintenance schedules.

267. How many times in the past year have emergency electricity backup systems for critical IT systems been activated, listed by date, duration of outage, likely cause?

Response to Question 267

Auckland DHB emergency electricity backup systems are designed with both Uninterruptable Power Source (UPS) systems (managed by healthAlliance) and backup generators (managed by the DHB).

UPS emergency electricity backup systems for critical IT systems have been activated 12 times in the past year across Auckland DHB's two data centres, which are located at separate sites.

Half of these were expected as a result of planned outages during scheduled maintenance work.

There were two instances of electricity backup systems being activated due to transmission faults at the electricity supplier, Transpower.

There were four other unplanned power outages across the two sites, each lasting 10 seconds.

All backup systems worked as designed and there were no outages to IT systems during any of these power outages, either planned or unplanned.

A full list of emergency electricity backup system activations are outlined below.

Datacentre	DHB	UPS runtime during power outage	Date	Start	End	Duration	Cause
AKH DC	ADHB	approx. 1hr 30min	14/02/2018	7:01:00	7:02:00	0:01:00	Planned outage. DHB Facilities team performed Generator Test
AKH DC	ADHB	approx. 1hr 30min	09/04/2018	11:37:29	11:37:39	0:00:10	Unplanned power outage
GLH DC	ADHB	approx. 1hr 30min	09/04/2018	11:37:29	11:37:39	0:00:10	Unplanned power outage
AKH DC	ADHB	approx. 1hr 30min	10/04/2018	21:14:49	21:14:59	0:00:10	Unplanned power outage
GLH DC	ADHB	approx. 1hr 30min	10/04/2018	21:14:49	21:14:59	0:00:10	Unplanned power outage
AKH DC	ADHB	approx. 1hr 30min	01/05/2018	10:59:24	10:59:43	0:00:19	Unplanned power outage, Transmission fault by Transpower
GLH DC	ADHB	approx. 1hr 30min	01/05/2018	10:59:24	10:59:43	0:00:19	Unplanned power outage, Transmission fault by Transpower

GLH DC	ADHB	approx. 1hr 30min	10/06/2018	13:24:21	13:24:33	0:00:12	Planned outage. DHB Facilities performing generator upgrade work
GLH DC	ADHB	approx. 1hr 30min	10/06/2018	14:04:58	14:06:34	0:01:36	Planned outage. DHB Facilities performing generator upgrade work
GLH DC	ADHB	approx. 1hr 30min	17/06/2018	8:37:04	8:37:14	0:00:10	Planned outage. DHB Facilities performing generator upgrade work
GLH DC	ADHB	approx. 1hr 30min	17/06/2018	8:39:54	8:39:59	0:00:05	Planned outage. DHB Facilities performing generator upgrade work
AKH DC	ADHB	approx. 1hr 30min	15/08/2018	6:30:15	6:30:30	0:00:15	Planned outage. DHB Facilities team performed Generator Test

268. Does the organisation have cyber insurance?

Response to Question 268

Yes, ADHB has Cyber insurance.

269. Is organization cyber security status and issues a regular reporting function to the board and if so what is the pathway and how frequently?

Response to Question 269

Yes, a report is provided by healthAlliance to the board every 6 weeks.

270. How many times in the past year has the organization received cyber security advice from the Ministry of Health?

Response to Question 270

ADHB is in regular contact with the MoH on Cyber security issues, liaising directly with the Chief Security Advisor. ADHB is also currently working with the MoH and Pharmac on developing a framework for purchasing Medical Devices that meet required Cyber Security standards.

271. When was the last time organizational cyber security status was reported directly to the board?

Response to Question 271

A report is provided by healthAlliance to the board every 6 weeks, the last meeting was 7th November.

272. Does the organisation have any evidence of cyberattacks on the external firewall from Russia and if so, what is the nature of that evidence?

Response to Question 272

healthAlliance's Northern Region DHB perimeter firewalls continually monitor, detect and block unauthorised traffic from sources all over the world. It is not always possible to ascertain the precise origin of this traffic or its intent. However, no direct attacks from Russia have been detected.

273. How many times in the past year have any cyber security breaches been referred to the privacy commissioner?

Response to Question 273

There were no cyber security incidents requiring referral to the Privacy Commissioner in the past year.

274. How many times in the past year has the organisation reported cyberincidents to the National Cyber Security Centre, CERT NZ, or the Ministry of Health, listed by organisation reported to?

Response to Question 274

healthAlliance has reported:

- two incidents to NCSC (one submission of malware for specialist analysis and another which turned out to be a false positive)
- one incident to the Ministry of Health (also a false positive)

275. Did the DHB have any data in the December 2017, 1.7 billion stolen electronic credentials found by US based cyber security research firm 4iQ?

Response to Question 275

There were 1048 email addresses from the four Northern region DHBs in the 4iQ report of a compendium of previous data breaches being available on the dark web. healthAlliance already had reports of the individual data breaches from which the compendium was made up (e.g. the 2012 LinkedIn hack).

Of the 1048 email addresses, many were inactive and posed no risk. The users of the remaining active email addresses were notified and had their passwords reset as a precaution. No unusual activity was detected in any of the associated accounts.

276. Did the Ministry of Health notify the organisation that they had at risk data in the stolen 1.7 billion electronic credentials found by US based cyber security research firm 4iQ?

Response to Question 276

The Ministry of Health, via its Chief Security Advisor, issued an alert advising of the 4iQ report.

healthAlliance pro-actively and continuously monitors all reports of database breaches via its threat intelligence sources and through its free subscription to haveibeenpwned.com. healthAlliance is automatically alerted if any of its credentials or email addresses appear online, on the dark web, or as part of a reported breach. When alerted, the standard process is to inform DHB CIOs and affected users if an email address, username or password is identified as being part of a breach. Passwords are reset as a precaution on those accounts. There have been no reports of any credentials appearing on the dark web separate to the 4iQ report

277. If the organisation was notified of at risk stolen electronic credentials identified by US security firm 4iQ, what steps did the organisation take, listed by date and action?

Response to Question 277

healthAlliance, acting on behalf of the DHB, contacted affected users and reset their passwords as a precautionary measure between December 16 and December 18 2017.

278. What proportion of the organisation's cyber security hardware originates from Chinese manufacturers, or make an estimate?

Response to Question 278

The regional shared IT service provider, healthAlliance, only procures cyber security systems and hardware from reputable, market-leading international suppliers, none of which are Chinese or Chinese-based.

It is not possible to calculate the proportion of hardware originating from China in an IT enterprise as large and complex as the Northern Region DHBs'

279. How does the organisation assess cyber bullying in the workplace?

Response to Question 279

Auckland DHB has a Harassment and Bullying policy. The purpose of the policy is to ensure all staff know their rights and responsibilities regarding workplace bullying and harassment. The policy provides definitions of bullying and harassment and describes the type of behaviour so that staff and management can identify the behaviour if and when it occurs. Bullying is described as a form of harassment. It is behaviour directed towards a person or group of people within Auckland DHB that is:

- Repeated;
- Unreasonable; and
- Creates a risk to health and safety

Bullying can impact on the health and well-being of the victim in more subtle ways. Examples of bullying and harassment and inappropriate behaviour using the internet, telephone and texts are included in the policy. Employees who believe they have been bullied, including cyber bullying, are encouraged to 'Speak Up' by a well-publicised anti bullying campaign run by Auckland DHB.

280. What evidence is there for cyber bullying across the organisation?

Response to Question 280

There are no reported incidences or evidence of cyber bullying across the organisation at this time.

281. What policies are in place for cyber bullying and please attach a copy of these policies?

Response to Question 281

There are no dedicated cyber bullying policies. Cyber bullying is covered by the Auckland DHB "Speak Up" programme, which is attached within the Harassment and Bullying policy.

282. Is cyber bullying formally reported to the board?

Response to Question 282

Yes. Serious incidents of bullying (including cyber bullying) and harassment are reported to the board. The board is made aware of disciplinary action taken when an allegation of bullying is upheld.

283. How many internet or sector facing applications does the organisation have that do not require 2 factor authentication?

Response to Question 283

There are five legacy internet or sector facing applications that do not require 2 factor authentication (2FA). Risk and relevant 2FA security measures will be assessed for each of these applications at the time of their next scheduled upgrade.

284. Which IT systems have had write downs, balance sheet contingencies placed against them, or otherwise reduction in valuation other than depreciation, listed by systems name and type and amount?

Response to Question 284

There were no write-downs of IT/IS systems owned by Auckland DHB.

285. Identify the IT projects with a total budget > \$100,000 currently in progress listed by project, start date, cost to date, budget to date, projected completion date, budgeted completion date.

Response to Question 285

ADHB's IT projects are mostly managed by our IT Shared Service (healthAlliance), a small number are managed directly by ADHB. Please note that neither healthAlliance nor ADHB record the budgeted completion date.

ADHB, 33 Projects

healthAlliance, 28 Projects for ADHB only, 5 Projects for ADHB and 1 or more regional DHB, 120 Northern Region projects (ADHB funds a share)

Details in [Question 285 – Appendix 1](#)

286. Identify the IT projects with a total budget > \$100,000 currently in progress and create a risk matrix for these projects as described in the government ICT risk assessment template document.

<https://www.ict.govt.nz/assets/ICT-System.../Risk-Assessment-Process-Template.docx>

Response to Question 286

For the purposes of this reporting we have taken all active projects >\$100k and assessed their risk rating as at 1st July 2018. Of the 187 projects 8 had a medium or high risk status. The impact of

these risks being realised is low - medium. All projects that have medium/high or severe risk ratings have clear go to green plans which are reviewed by the Project Manager regularly and the Sponsor if required.

This response does not include healthAlliance managed projects

Project Name	Start Date	Budget	RAG Status at 31/7/18
CSSD Single Instrument Tracking	May-15	\$1,317,742	Red
Delphic Core Upgrade	Dec-15	\$353,886	Red
Ophthalmology Patient Flow Implementation	Jul-15	\$416,350	Red
Patient Email & Mobile No Validation	Aug-17	\$181,004	Amber
Muse Replacement	Aug-17	\$329,301	Amber
MFM Viewpoint Upgrade	Nov-17	\$315,933	Amber
Imagenet Upgrade	Dec-17	\$464,038	Amber
Enterprise Asset Management (for Allied Health)	Mar-18	\$955,481	Amber

287. Identify the IT projects with a total budget > \$100,000 currently in progress and create a traffic light assessment for these projects as described in the SSC large projects risk assessment document.
https://www.ssc.govt.nz/sites/all/files/monitoring-guidance_0.pdf

Response to Question 287

The ADHB methodology uses a Project Complexity Assessment Tool and where required the Treasury Risk Profile Assessment tool to indicate the risk and complexity level of a project. This drives appropriate governance and assurance activities. Portfolio level assurance is scheduled to ensure compliance of QA Activities.

SSC large project risk assessment is typically used for larger business cases of which Auckland DHB did not have any active IT projects in 2017/2018.

288. Identify IT projects which are challenged by all or any one of scope, time or cost?

Response to Question 288

This response is for ADHB managed projects only. It excludes projects managed by healthAlliance:

The following projects are challenged by scope, time and/or cost:

CSSD Single Instrument Tracking - time and scope

Ophthalmology Patient Flow Implementation - time and cost

Growth Chart Publishing - time and cost

Genetics Clinical Database - time

Hepatocellular carcinoma dbase - time

Delphic Core Upgrade - cost

eReferrals Inter & Intra DHB - time

Virtual Reality Implementation - time and scope

Adaptive IT System Fert. Plus - time, scope and cost

Patient Email & Mobile No Validation - time and cost

MFM View Point Upgrade - time

MUSE Replacement - time

ImageNet Upgrade- time

Enterprise Asset Management (for Allied Health) - time, cost and scope

289. Identify IT projects which are challenged and which have consequently been discussed with the Ministry of Health and what are those challenges?

Response to Question 289

This response is for ADHB managed projects only. It excludes projects managed by healthAlliance:

MOH has been notified of these issues via project quarterly reporting

Enterprise Asset Management (for Allied Health) - Solution as scoped may not be able to meet all business requirements, pre-requisite upgrade is taking longer than expected, project is behind schedule and budget is at risk.

CSSD Single Instrument Tracking - Replacement system for CSSD, selected via a regional procurement process could not meet some critical requirements due to the unique architecture of ADHB systems. Significant time was spent trying to resolve this. Subsequently the scope was changed to upgrade the existing system and the single instrument tracking functionality was removed from scope. Budget is not at risk.

290. What is the organisation's total investment in the National Oracle Solution to date?

Response to Question 290

Auckland DHB's total investment in the National Oracle Solution Asset as at November 2018 is \$11,052,830.

291. What amount has the organisation written off to date for the National Oracle Solution?

Response to Question 291

\$2.774M was written off as at 30 June 2018 based on best information available. If approval is given for the programme to continue some of this write-off would be reversed.

292. Will the organisation be writing off or making a contingent liability or other similar accounting entry for the National Oracle Solution?

Response to Question 292

Write offs against the NOS are based on formal impairment assessments completed at the end of each financial year. Other than the write off noted per response to Question 291, we are not anticipating any further write-offs unless the project does not proceed as planned and the impairment assessments suggests a further write off is required. There are no contingent liabilities declared in relation to NOS in the audited accounts as at 30 June 2018. Under any of the options for moving forward (either a National System or DHB clusters) use of the NOS assets developed nationally to date, is the most practical and cost effective option.

293. What is the estimated deployment and operational costs for the National Oracle Solution listed by deployment cost and operational cost?

Response to Question 293

Due to the pause it is not possible to confirm the deployment cost and timing. For Auckland DHB the system in use needs to be significantly upgraded. All indicative costings we have are that to either significantly upgrade our current system or move to the NOS system the implementation costs would be the same and these are estimated as being between \$3.5m and \$4m for ADHB. ADHB's last significant upgrade of the system eight years ago cost \$3.2m. Future Licensing and system administration costs are expected to be similar whether the current Northern region system is upgraded or a NOS solution with wider DHB coverage proceeds. There are future economies of scale possible if DHBs proceed with a shared system.

294. Does the organisation consider their investment in the National Oracle Solution to date to be a good investment?

Response to Question 294

ADHB has not yet been rolled into NOS. ADHB is working with other DHBs regionally and nationally to progress the NOS solution. This project, if completed as planned in the Change Case that was signed off by the Board in 2017, would address the risks facing the Northern region DHBs and enable procurement benefit realisation.

295. Does the organisation support further development of the National Oracle Solution and if so, what are the quantifiable business case benefits to the organisation?

Response to Question 295

ADHB is working with other DHBs regionally and nationally to progress NOS implementation. This project if completed as planned will

- address DHB system related risks,
- provide enhancements that enable cost savings in the Northern region (approx. \$2m per annum)
- enable all DHBs to meet real time compliance with a National Contracts and a National catalogue; this would enable projected Pharmac procurement savings of up to \$40million per annum for the DHB sector.

ADHB and other northern DHBs are currently operating an old unsupported version of Oracle and need to upgrade the system to a newer supported version by 2020 at the latest.

296. Is the organisation prepared to further invest in the National Oracle Solution?

Response to Question 296

ADHB is committed to further investment in NOS as approved by the DHB Board. ADHB and the Northern region need to upgrade the current financial system and it is more cost effective for the Northern Region to utilise the NOS system in place in four DHBs and build the infrastructure that has already been procured and designed than to have to replace our existing system not utilising any of the assets developed under NOS so far.

297. How much is the organisation budgeting for all activities related to the National Oracle Solution in the upcoming year?

Response to Question 297

ADHB's 2018/19 capital budget includes \$3.2M set aside for NOS project. \$1.4m has been paid to date (Nov-18). ADHB is working regionally and nationally to establish the timing requirements of the remaining balance following the NOS implementation "Pause" decision.

298. If the organisation is not one of the 4 DHBs receiving further National Oracle Solution support by government, that is, the National Oracle Solution is "paused" in this DHB, what notice and communications did the organisation have with the Ministry or Health Partnerships Ltd about this decision, listed by date and nature of communication ?

Response to Question 298

The Ministry of Health Director General sent a letter to DHB Board Chairs on 28 June 2018 advising of the Cabinet's decision to Pause NOS. In response, ADHB worked with Northern region DHBs, HealthBIS DHBs and Southern DHBs to progress an alternative business case in order to address significant risks faced by these DHBs as a result of the pause decision, including linkage to the business case being progressed by NZHPL in response to the Pause decision. ADHB is now working nationally with other DHBs and NZHPL to develop a single business case in response to the pause decision. A single business case is now being developed led by NZHPL and with input ADHB is now working with NZHPL and other national DHBs to progress the revised NOS business case.

299. If the organisation is not one of the 4 DHBs receiving further National Oracle Solution support by government, that is, the National Oracle Solution is "paused" in this DHB, is the organisation pleased or displeased to be one of the DHBs that is "paused" ?

Response to Question 299

ADHB is facing significant risks that are anticipated to be addressed by progressing the NOS. ADHB is working regionally and nationally with other DHBs and NZHPL to progress NOS.

300. If the organisation is not one of the 4 DHBs receiving further National Oracle Solution support by government, that is, the National Oracle Solution is "paused" in this DHB, what is the organisation's position on being "paused" ?

Response to Question 300

ADHB is facing significant risks that need to be addressed. ADHB is working regionally and nationally with other DHBs and NZHPL to progress NOS. ADHB needs clear decisions to be made by the whole sector so progress can be made to address system risks and improve financial performance. There is a cost and an increase in risk resulting from delay in decision making.

301. How much has the organisation paid to Deloitte or Deloitte related entities e.g. Asparona in the past year for any services associated with the National Oracle Solution?

Response to Question 301

ADHB has not made any payments to Deloitte or Deloitte related entities e.g. Asparona in the past year for any services associated with the National Oracle Solution. NZHPL is responsible for implementation of NOS and any related costs are paid by NZHPL.

302. Does the organisation believe Deloitte or Deloitte related entities e.g. Asparona have a conflict of interest with the National Oracle Solution?

Response to Question 302

ADHB was not involved in the Ministry of Health decision to contract Deloitte to review the Change Case so we are unable to make any assessment with respect to whether there was a conflict of interest or not.

303. Does the organisation have any evidence that Deloitte or Deloitte related entities e.g. Asparona have a conflict of interest with the National Oracle Solution?

Response to Question 303

ADHB is not in a position to respond to this question. This should be addressed to NZHPL.

304. What average amount of health funding for the whole DHB population, per capita, is received by the DHB, listed by year for the past 4 years?

Response to Question 304

Year	ADHB Population	ADHB funding for its population	ADHB funding per capita
2014/15	475,765	\$1,018,664,473	\$2,141
2015/16	482,015	\$1,058,524,300	\$2,196
2016/17	510,450	\$1,102,896,347	\$2,161
2017/18	530,460	\$1,151,746,535	\$2,171

305. How many elective surgeries were performed, per capita (whole DHB population except primary care), listed by year for the past 4 years?

Response to Question 305

Financial Year	Elective Surgery ADHB	DHB Population ADHB	Per 10,000 Population ADHB
2014/15	13096	471,840	277.6
2015/16	14476	490,000	295.4
2016/17	14343	507,270	282.7
2017/18	14937	523,580	285.3

306. How many people were attended to by the DHB (across all services except primary care), per capita (whole DHB population), listed by year for the past 4 years?

Response to Question 306

	2014/15	2015/16	2016/17	2017/18
Patients seen at ADHB	140,978	144,037	146,525	149,258
Patient population as at 30 June 2018	490,000	507,200	523,500	536,800
Patients seen at ADHB per 10,000 population	2,877	2,840	2,799	2,781

307. What is the average utilization of operating theatre time across the campus, listed by year for the past 4 years?

Response to Question 307

Elective sessions only

Scheduled Session = Actual sessions + Cancelled sessions

*Utilisation refers to the amount of time the patient is in the operating room during the used sessions. The international benchmark is 80% -85%. Usage of OR's remains stable at approx. 97%.

	2014/15	2015/16	2016/17	2017/18
Theatre time utilisation*	84%	83%	84%	84%
Actual Sessions	9587	9890	9923	9747
Cancelled Sessions	983	1114	922	905
Scheduled Sessions	10570	11004	10845	10652
% Scheduled vs. Actual	91%	90%	91%	92%

308. What is the average in patient bed utilization rate across the whole campus, listed by year for the past 4 years?

Response to Question 308

Inpatient utilisation has been calculated by taking midnight patient occupancy compared to resourced beds available. Utilisation has been calculated across all Auckland DHB sites containing inpatient beds, including Auckland City Hospital, Starship Hospital, Greenlane Clinical Centre and all mental health facilities. Day case, emergency department and post-operative recovery beds have not been included.

2015	85%
2016	84%
2017	84%
2018	87%

It should be noted that during 2018, there was a net increase of five beds compared to 2017, bringing the total resourced bed base across all sites and services to 1,210.

309. Does the organization support DHB amalgamation?

Response to Question 309

Please refer to question 310

310. If the DHB was to amalgamate, which DHBs would you amalgamate with and what would be the advantages and disadvantages to you?

Response to Question 310

We believe there would be advantages to the creation of a commissioning organisation across metro Auckland DHB.

Merger of the three metro Auckland DHBs in totality would create an organisation larger than any business NZ has ever experienced.

Evidence from other domains would suggest the creation of large provider organisation have little benefit, threaten all employees and take at least 5 years to embed. The size of the organisations on multiple sites would require duplication of much of the current management structure.

The advantages could be achieved through the creation of a single commissioning organisation.

311. How many PHOs provide services to the DHB?

Response to Question 311

Refer Question 180

312. How many PHOs cross operational boundaries with other DHBs including your own ?

Response to Question 312

Four

313. Does the organization support restrictions to PHO such that they do not operate across DHB boundaries, and if not why not ?

Response to Question 313

Currently four of our five PHOs operate across DHB Boundaries. While this has led to complexity in terms of the contracting arrangements, it does support a more consistent metro Auckland regional approach. This is important given that patients are not necessarily aware of DHB boundaries. It also means there is a high level of regional collaboration and sharing of best practice, for example the seven PHOs in the region and the three DHBs all work together to deliver the Metro Auckland System Level Measures Quality Improvement Plan.

It can be challenging when PHOs cross boundaries not in one region, for example National Hauora Coalition operates across the metro Auckland region as well as Waikato and Waikato.

The national PHO Services Agreement process can make multi-district PHO arrangements complex, as although we have five PHOs operating in our district we are only the lead DHB for two. This impacts on transparency of funding and reporting, which we mostly mitigate thanks to close working relationships with Auckland and Waitemata DHBs. Ideally a 1:1 relationship PHO/DHB would be preferable should it be determined PHOs add value.

314. How many breast reconstructions are done annually?

Response to Question 314

17 per year based on the average over the last two years.

315. What percentage of reconstructions are done within a year following mastectomies?

Response to Question 315

64% had a reconstruction at the same time or within 12 months.

316. What is the average DHB cost of single and double mastectomy reconstructions?

Response to Question 316

Average cost for Unilateral (single) is \$11,189 and for Bilateral (double) \$12,008

317. How many Pasifika people visiting from the islands have dialysis in the DHB listed by year?

Response to Question 317

We have had just one patient from the Pacific Islands in the last 2 years who underwent 2 or 3 dialysis sessions

318. What percentage of people doing dialysis are Pasifika people and Māori, listed by ethnicity?

Response to Question 318

The attached file shows the data for incident and prevalent patients as of 31/12/2016.

The data for 2017 is "locked" and will be available mid-next year.

319. What are the average annual costs of an individual's annual and all of life dialysis costs and on average how many years is dialysis performed?

Response to Question 319

The average full year cost of dialysis treatment per patient for the different modalities ranges from \$28,000 to \$53,000. Note this is for dialysis treatment only (no other outpatient visits, etc.) and the costs for individual patients may vary above or below this.

The overall average annual cost for dialysis treatment per patient is \$46,000.

The average survival on dialysis is just under five years. Healthier patients may be suitable for transplantation which incurs different costs and has a longer life expectancy.

320. What statistics does your organisation keep to inform initiative(s) to support New Zealand's Smokefree 2025 target?

Response to Question 320

Number of inpatient events and primary care enrolled patients Coded by ethnicity, gender who are

- Current smokers

- Ex-smokers

- Never smoked

-Smoking prevalence

-% of people who smoke given advice /support

Maternity

Number of events coded by ethnicity who are

-Number of Smokers

-Smokers' gestation (weeks)

-% offered brief advice

-% offered advice and support to quit

-% accepted cessation support

-Smoking prevalence

Number of referrals received and number of referrals triaged to Quitline, local Stop Smoking Services, GPs, out of area Stop smoking services providers or declined referral. Number reported by

-Ethnic group

-Gender

-Pregnancy

Number of referrals received, enrolled and quit outcomes for local stop smoking services and pharmacy stop smoking service, number reported by;

-Ethnic group

-Gender

-Pregnancy

321. What initiative(s) are underway in your organisation to support New Zealand's Smokefree 2025 Target?

Response to Question 321

Auckland DHB Smokefree services continues to provide leadership, including clinical leadership, to promote quality smokefree interventions. This involves, embedding systems to support the delivery of Ask, Brief Advice, Cessation (ABC) in clinical practice, utilising systems to prompt the asking of smoking status, recording of brief advice and referral to cessation support.

The service:

- ensures training is available for all secondary care health professionals in the ABC approach and promotes eLearning including Effective Stop Smoking Conversations with Pregnant Women
- maintains and resources a network of Smokefree Leads for inpatient hospital services
- supports ADHB staff and offers brief advice, NRT and referral for support to stop smoking, smoking status updates and documents all interventions.
- works with cultural services to develop resources specifically for Māori and Pacific smokers
- has set a hospital target for the percentage of smokers by ethnicity that agree to make a supported quit attempt (prescribed NRT and/or accept a referral to a Stop Smoking Service

Auckland DHB Mental Health and Addiction (MH&A) Services employs a smokefree coordinator to provide leadership to promote quality smokefree interventions, embedding systems to support the delivery of ABC in clinical practice. The Northern Regional Alliance has a similar role to support MH&A NGOs. The services

- ensure training is available for all MH&A health professionals in the ABC approach and promotes eLearning including Effective Stop Smoking Conversations with Pregnant Women
- maintains and resources a network of Smokefree Leads in some MH&A teams
- leads a group based incentivised quitting challenge

Auckland DHB has a contract with each PHO to employ a smokefree coordinator and provide leadership, including clinical leadership to promote quality smokefree interventions, embedding systems to support the delivery of ABC in clinical practice, utilising systems to prompt the asking of smoking status, recording of brief advice and referral to cessation support. The PHOs

- ensure training is available for all primary care health professionals in the ABC approach and promotes eLearning including Effective Stop Smoking Conversations with Pregnant Women
- maintain and resource a network of Smokefree Leads for in general practices
- support practice staff to offer brief advice, NRT and referral for support to stop smoking, smoking status is updated and all interventions documented and coded and reported for the 'better help for smokers to quit' health target

Auckland DHB has included 'smoking cessation' as a measure in the primary care Amenable Mortality - System Level Measure.

Auckland DHB has a contract with 18 community pharmacies to deliver face-to-face stop smoking services that includes NRT and behavioural support over a month.

Auckland DHB funds the MOH contracted local stop smoking support service (Ready Steady Quit) for incentives for pregnant women and their whānau to stop smoking. The pregnant woman can receive up to \$350 in vouchers and the whānau member up to \$200 in vouchers.

Auckland DHB is training smokefree champions in about 40 Pacific churches / community groups.

322. What work is being done in your organisation to promote electronic cigarettes and vaping as a less-harmful alternative to smoking?

Response to Question 322

Following consultation Smokefree policies will be updated where applicable to include vaping and other products that are not smoked (e.g. Heat not burn).

ADHB follows the Ministry of Health guidance on using electronic nicotine delivery devices (ENDS) products as a device to assist with stopping smoking.

Health care practitioners are supported to provide accurate information to people about vaping

323. Did you receive a letter of expectation from the Minister of Health for mental health? If , what did it say?

Response to Question 323

We have received a letter of expectations for district health boards from the Minister of Health for 2019/20. Please refer to [Question 323 – Appendix 1](#)

324. What instructions have you received from the Ministry of Health about mental health?

Response to Question 324

We have been advised not to make significant change to mental health and addiction services, pending the outcome of the Mental Health and Addiction Inquiry.

325. What was the total amount of ring-fenced funding your DHB received for mental health in 2017/18?

Response to Question 325

The DHB doesn't receive ring-fenced funding for mental health. We receive overall funding for all services for our population based on the PBFF funding formula. The Ministry provide annual advice regarding our mental health ring-fence expenditure position. For 2017/18 this was \$154,700,000.

326. What is the total amount of ring-fenced funding your DHB received for mental health each year for the last 5 years?

Response to Question 326

Please refer to Question 325.

YE Jun-18 (000)	YE Jun-17 (000)	YE Jun-16 (000)	YE Jun-15 (000)	YE Jun-14 (000)
\$ 154,700	\$ 148,200	\$ 143,600	\$ 138,200	\$ 134,300

327. What was the average wait time for Child and Adolescent Mental Health Services for 2017/18?

Response to Question 327

Service	FY 2018 (days)
Kari Centre	28.0
Regional Youth Forensic Services	7.8
<i>All Community Services</i>	21.9
Child and Family Acute Inpatient Unit	0.5
<i>All Services</i>	18.3

Notes:

1. Wait-times are in days, averaged over all referrals received within the financial year and seen face-to-face. Includes referrals seen on same day as date referred (zero days waiting).
2. Referrals not seen face-to-face before being closed (declined) or still waiting to be seen face-to-face are not included in calculations
3. Wait-times for the Child & Family Unit should not necessarily be seen as a delay in providing a bed (i.e. as an imposed "wait"). As a supra-regional service, time between referral and admission can often be related to managing the admission and travel process for instance. In some cases, referrals are made when an admission seems likely but this may not proceed immediately for clinical reasons.

328. What was the average wait time for Child and Adolescent Mental Health Services for each year for the last 5 years?

Response to Question 328

Service	Financial Years (days)				
	2014	2015	2016	2017	2018
Kari Centre	14.4	18.8	17.9	22.1	28.0
Regional Youth Forensic Services	9.7	10.9	10.7	6.5	7.8
<i>All Community Services</i>	13.2	16.6	16.0	17.0	21.9
Child and Family Acute Inpatient Unit	1.5	0.8	0.8	0.7	0.5
<i>All Services</i>	10.8	13.5	12.9	14.2	18.3

Notes:

1. Wait-times are in days, averaged over all referrals received within the financial year and seen face-to-face. Includes referrals seen on same day as date referred (zero days waiting).
2. Referrals not seen face-to-face before being closed (declined) or still waiting to be seen face-to-face are not included in calculations

3. Wait-times for the Child & Family Unit should not necessarily seen as a delay in providing a bed (i.e. as an imposed "wait"). As a supra-regional service, time between referral and admission can often be related to managing the admission and travel process for instance. In some cases, referrals are made when an admission seems likely but this may not proceed immediately for clinical reasons.

329. What were the average individual wait times for Child and Adolescent Mental Health acute services, community services and other service settings?

Response to Question 329

Kari Centre integrates acute, community and more specialised (e.g. neuro-developmental, infant) services. As such it serves as a single point of referral from which new referrals are triaged and allocated as appropriate. It is not straightforward, therefore, to breakdown referrals and wait-times in acute, community and other groupings as requested: Acute/urgent referrals are identified and seen within set timeframes; other referrals may be initially seen by an intake/assessment team and then referred on internally as appropriate. Some referrals are sent directly to community or specialist teams. An overall figure has instead been provided.

Service	Financial Years (days)				
	2014	2015	2016	2017	2018
Kari Centre	14.4	18.8	17.9	22.1	28.0
Regional Youth Forensic Services	9.7	10.9	10.7	6.5	7.8
<i>All Community Services</i>	13.2	16.6	16.0	17.0	21.9
Child and Family Acute Inpatient Unit	1.5	0.8	0.8	0.7	0.5
<i>All Services</i>	10.8	13.5	12.9	14.2	18.3

Notes:

1. Wait-times are in days, averaged over all referrals received within the financial year and seen face-to-face. Includes referrals seen on same day as date referred (zero days waiting).

2. Referrals not seen face-to-face before being closed (declined) or still waiting to be seen face-to-face are not included in calculations

3. Wait-times for the Child & Family Unit should not necessarily seen as a delay in providing a bed (i.e. as an imposed "wait"). As a supra-regional service, time between referral and admission can often be related to managing the admission and travel process for instance. In some cases, referrals are made when an admission seems likely but this may not proceed immediately for clinical reasons.

330. How do DHB settings inform patients that they may be asked to take part in research and what are the consent protocols?

Response to Question 330

ADHB has an academic health alliance with the University of Auckland and we are an academic institution with nearly every clinical department engaged in clinical research. Research is publicised as part of DHB activity and celebrated in our annual research week and with the publication of an

annual research report. Research that involves human participants is governed by the principles of the Declaration of Helsinki (2013) and through approval by the MOH Health and Disability Ethics Committees (HDEC). ADHB has a framework for the governance of research with a Research Office that registers all projects, a Research Review Committee and a Research Governance Committee. All staff participating in research must comply with ADHB research policies. Specific research projects may be advertised in the service, in the public arena e.g. local newspapers or via NGOs/GP practices/patient interest groups. Research consent is taken according to HDEC ethical guidance. It is informed, it is free of coercion and the participant is competent or has an approved guardian who can legally give consent on their behalf e.g. parent. Written information is provided about the research project (HDEC provides a standard template) and written consent is provided. If necessary, information is provided in the language of choice. Hospitals that participate in research have better health outcomes and that applies whether patients were enrolled in research projects or not. Patients who are involved in research projects have better health outcomes even if administered a placebo therapy.

331. Please provide information on the nature of the research projects being undertaken i.e. best practice, efficacy of medical devices or pharmaceuticals.

Response to Question 331

ADHB staff lead or participate in research projects of the following nature:

- Sponsored clinical trials involving devices and pharmaceuticals
- Phase 1 first in man clinical trials, phase 2a/b safety and efficacy trials, phase 3 broader efficacy trials and phase 4 post marketing surveillance. These trials may be investigator initiated or industry sponsored commercially contracted trials
- Investigator initiated studies of non-therapeutic interventions e.g. new diagnostics or new applications of existing diagnostics
- Investigator initiated observational studies including epidemiologic studies
- Quantitative and qualitative research methodologies are employed including Kaupapa Maori methodologies.

332. How many research projects are clinical trials and what pharmaceutical companies are specific DHBs collaborating with?

Response to Question 332

ADHB has 279 active studies that are clinical trials. Of these, 129 are investigator-led non-commercial studies and 150 are sponsor-led commercial studies. We are contracted to undertake commercial clinical trials by 79 different organisations (see the breakdown below). Sometimes the organisation we contract with is not the sponsor organisation but its local representative (a contract research organisation such as Covance or Quintiles). Companies involved and the number of research projects:

Abbvie	2
Actelion Pharmaceuticals	1
Agenus Inc	1
Amgen	1
AstraZeneca Ltd	1

Bard Peripheral Vascular	1
Beigene Ltd	6
Biogen Research Ltd	3
Biotronik	1
Boehringer Ingelheim	1
Boston Scientific	4
Breathe Easy Ltd	1
Bristol-Myers Squibb	1
CBT Pharmaceuticals	1
Celgene	1
ChemoCentryx, Inc.	1
Clinical Network Services	1
Clovis Oncology	1
Cook Incorporated	1
Covance	2
Covidien	1
CSL Behring	1
Daiichi Sankyo Pharma Development	1
Dynavax Tech Corp	1
Edwards Lifesciences	2
Eiger BioPharmaceuticals	1
Eisai Ltd	1
Eli Lilly	4
Elixir Medical Corporation	1
F. Hoffman-La Roche Ltd	4
Fisher and Paykell Healthcare	1
Genetech	1
George Clinical Pty	1
Gilead Sciences Inc	10
GlaxoSmithKline	1
Green Lane Coordinating Centre	2

ICON Clinical Research	1
INC Research	2
Infinity Pharmaceuticals	3
Intact Vascular	1
InterVene Inc	1
inVentiv Health	1
Janssen-Cilag	1
JVT Research and Development Corp	1
Living Cell Technologies	2
MedImmune	1
Medpace Clinical Research	1
Medtronic	3
Merck Sharpe and Dohme	14
Metavention	1
Millennium Pharmaceuticals	2
Novartis Pharmaceuticals	1
Novo Nordisk Pharmaceuticals	1
Novotech	6
Onyx Pharmaceuticals	1
Parexel	1
Pfizer	3
Pharma net	1
Pharmacyclics Inc	2
PPD Global Ltd	4
Quattro Vascular Pte Ltd	1
Quintiles	1
REVA Medical Inc	1
Roche Products (New Zealand) Ltd	7
Sanofi-Aventis	2
Shape Medical	1
Shockwave Medical Inc	3

SillaJen Inc	1
Solvay Pharmaceuticals	1
Sunesis	1
Symic Vascular Inc	1
Targovax ASA	1
Tobira Therapeutics	1
Visterra Inc	1
W.L. Gore and Associates	1
Wyeth Australia	1
Zenith Tech Corp	2
Zhejiang Medicine Co. Ltd.	1
Zynerba Pharmaceuticals	2

333. Please provide examples of how this research has added value to clinical practice.

Response to Question 333

The HSC is referred to the annual research report where examples of research translation into clinical practice are described, and a list of publications appended.

[2017 Auckland DHB Annual Research Report](#)

334. Do you have a research strategy?

Response to Question 334

Yes. The three year strategy was developed in 2016 and involved participants from metro DHBs, the University of Auckland and the Health Research Council. The three goals are:

- Improve focus, coherence and positive impact of ADHB research
- Sustain and enhance the world-class ADHB research workforce

- Reap the benefits from increasing ADHB's share of the externally-funded health research market

The strategy will be refreshed in 2019 but it is already recognised that equity will be a pillar of the new strategy. ADHB research leads have also participated in the new NZ Health Research Strategy and its implementation.

ADHB has an academic health alliance with the University of Auckland which administers shared research funding aimed at building research capability and capacity, increasing the translation of research and securing larger investigator initiated research grants.

335. Please advise what your DHB has done, and plans to do, to address this matter; what recent progress has been made; and when the matter is likely to be resolved.

Response to Question 335

A national DHB framework to enable a full review of Holidays Act compliance has been developed in partnership with the Council of Trade Unions and MBIE and is with the Ministry of Health for consultation. Provisional liability reporting based on a high level review has been done and provisions have been communicated in our annual report. Completion of the full review will be required to determine any further liability.

336. If available, please provide an estimate of the potential liability to your DHB. If the best current estimate is a range, please advise what the range is.

Response to Question 336

The DHB has a provision for this of \$6.9million. The liability is expected to be significantly higher (tens of millions of dollars); the DHB will assess the impact once a national framework for interpretation of the act has been agreed by all DHBs. Parts of the current act are subject to different interpretations when applied to the complex employment arrangements in the Health Sector. Even when final agreement around interpretation is reached it is likely to be difficult, costly and time consuming to implement in our electronic payroll system.

Question 15 – Appendix 1

Shelved or Curtailed Projects

Project Name	Budgeted Cost	Actual Cost to date	Purpose	Reason Not Completed
<i>Due to be completed in 2017/18 but pushed into out years</i>				
ADHB Managed Projects				
CSSD Instrument Tracking	1,317,742	569,909	To upgrade the sterile supplies system and implement single instrument tracing	Replacement software not fit for purpose, project scope changed to upgrade current system
Ophthalmology Patient Flow Imp	416,350	88,790	To implement patient check in kiosks and patient flow solution for the Ophthalmology Outpatient clinic	Multiple delays due to security concerns, infrastructure implementation issues and vendor software issues
ePrescribing Early Adopter	1,883,347	1,193,322	To implement ePrescribing into 2 wards	Delays with infrastructure implementation
Genetics Clinical Database	157,909	143,358	To implement a database to manage patients in the Genetics Service	Delayed due to performance issues with vendor software
Tracking System Pathology	350,000		To implement the regional histology tracking system	Delayed due to readiness of the service to implement
MPS Platform	368,530	288,713	To implement a new genomics system	Delayed due to technical complexity
Delphic Core Upgrade	353,886	230,087	To upgrade core laboratory system	Closure delayed due to delay in invoicing of costs
Pager Replacement Requirements	54,000	53,000	To determine requirements for replacement pager solution	Closure delayed whilst awaiting decision on paging solution
Planview Project Mgmt Implementation	62,750	40,830	To implement the PlanView project management	Awaiting delivery of time sheeting functionality from the vendor
eReferrals Implementation (DHB Costs)	79,800	45,455	Implementation of eReferrals online triage functionality	Delayed whilst awaiting system changes and improvements

CareConnect - CCMS Implementation continued	85,000	46,005	Implementation of regional shared care solution within ADHB	Delayed whilst awaiting agreed shared care strategy for ADHB
eMedicines Reconciliation	450,773	208,432	To implement eMedicines Reconciliation within ADHB	Delays due to service readiness for implementation
National Child Health Programme (NCHIP)	480,000	128,000	Implementation of National Child Health tracking system	Delays in vendor contract
Video Audio File storage system	98,640	57,897	To provide storage for audio and video files containing clinical information	Closure delayed whilst awaiting final growth predictions
healthAlliance Managed Projects				
ADHB Infection Prevention and Control System (ICNET) (3852)	499,964	499,947	To implement the ICTNet Infection Prevention and Control System	Delays with design and infrastructure build and integration
ADHB Metro PACS Upgrade (4405)	855,103	852,668	To upgrade the metro-Auckland DHBs PACS system	Delays in design, build and implementation
ADHB Prosolv application Upgrade (3421)	185,736	222,884	To upgrade the Prosolv cardiac Ultrasound PACS and reporting system	Closure delayed due to overspend
ADHB Publishing of Documents to electronic repositories (4419)	84,996	79,264	To publish addition documents from clinical systems to the Éclair document repository	Delays in design, build and implementation
ADHB Titanium V 52 to V 76 Upgrade (4463)	532,250	531,801	To upgrade the dental system to the latest version	Delays in design, build and implementation
ADHB Upgrade HCC Community Sexual Health(4299)	441,718	436,427	To upgrade to latest version of HCC for the community & Sexual Health services	Project closure delayed due to post go live issues
Regional EMM platform (4523)	2,385,000	2,385,000	Rollout out Enterprise Mobile Management solution	Delayed due to requirement for additional change management
<i>Due to be completed in 2017/18 but shelved or curtailed</i>				
ADHB Managed Projects				
Leave Management Planning Study	40,000	20,000	To plan implementation of leave management functionality in the HR system	Decision made not to proceed
Transgender Data Collection Da		-	Database to collect data on transgender patients	Solution did not meet functional requirements

	61,500			
Voice Recognition Software	424,938	167,464	To implement Voice Recognition functionality in the Winscribe dictation system	Cancelled due to unsuccessful pilot
EDS Optimisation	98,150	8,000	To implement national EDS standards	Decision made not to proceed
healthAlliance Managed Projects				
ADHB Upgrade HCC Diabetes (4407)	411,961	407,394	To upgrade to latest version of HCC for the Diabetes service	Cancelled as solution could not be tested successfully
Regional Paging Service Replacement (4553)	402,000	397,863	To replace regional paging solution	Cancelled due to technical deficiencies in selected solution
ADHB TCIWorks Drug Dosing Tool software Replacement (3937)	260	325	Scoping of requirements for TCIWorks Drug Dosing Tool Software	Cancelled due to decision not to proceed
ADHB Radiation Treatment Planning Systems (RTPS) (4615)	No budget set	-	Implementation of a Radiation Treatment Planning System	Cancelled as no longer required
ADHB MIM Virtualisation (4616)	No budget set	-	Virtual server for ADHB MIM System	Cancelled - decision not to proceed
Regional VPN Migration and Resilience (4980)	No budget set	-	Upgrade of regional VPN solution	Cancelled and included in scope of overall resilience programme
Regional Upgrade of Paceart (4914)	No budget set	-	Upgrade the regional Pacemaker management system	Cancelled as no budget available
ADHB ARPHS Discharge Letters to GP's (3900)	9,300	9,300	Send discharge letters to GPs for patients managed by Public Health service	Cancelled as no funding available to implement
ADHB New Technology for NZ MoH National Antenatal Screening Programme (4971)	No budget set	-	New system required to support/enable National Antenatal Screening Programme.	Cancelled as not yet required
ADHB Survey video prior to using hospital hotspot (4964)	No budget set	-	Survey and/or force watching of video prior to using hospital hotspot	Cancelled as no funding available to implement
ADHB Validation of HL7 messages from Aspire (4966)	No budget set	-	Review error handling for system messaging	Cancelled and included in scope of overall resilience programme
ADHB Vigilant ASE-NET Fire Systems Management System (4827)	5,000	4,055	Upgrade to the Vigilant ASE-NET Fire Systems Management System	Cancelled as no upgrade version available

19312 - Regional Tier 2 Storage Growth (5109)	-	-	Regional Tier 2 Storage Growth	Cancelled and included in scope of overall resilience programme
Regional Wifi Services (5084)	-	-	Regional Wifi Services	Cancelled and included in scope of overall resilience programme
Regional AD Functional Upgrade (5077)	100,000	-	Regional AD Functional Upgrade	Cancelled and included in scope of overall resilience programme
ADHB Cardiac Inherited Disease [CIDG] Software Enhancement (5167)	-	-	To establish a sustainable CIDG network and a web enabled clinical registry database.	Cancelled and included in scope of overall resilience programme
Regional Capacity Management and Reporting (5111)	-	-	Regional Capacity Management and Reporting	Cancelled and included in scope of overall resilience programme
ADHB CMH Agfa Xero Solution For Clinical Images (5210)	-	-	Implement Agfa Xero solution for capturing clinical images on mobile phones	Cancelled as no funding available to implement
Regional Paging Replacement Business Case (5209)	-	-	Business Case for replacement paging solution	Cancelled due to technical deficiencies in selected solution

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Question 25 – Appendix 1.

Vehicles 2017/2018

Fleet Number	Registration Number	Year of Manufacture	Make and model	Cost Centre	Location	Start date	De-commissioned
1052	BTJ351	2004	Toyota Hiace Van	445-4636	Buchanan Clinic	01/08/2010	
1068	BJU595	2003	Toyota Hiace	445-2031	SSH	21/08/2009	
1333	EFG468	2006	Hyundai Getz	445-4633	Taylors Centre - Ponsonby		31/05/2018
1353	DNK424	2006	Hyundai Getz	445-4626	Panmure	04/04/2013	
1355	DNK423	2006	Hyundai Getz	445-4626	Panmure	04/04/2013	
1425	DNU448	2006	Hyundai Getz	415-3646	Greenlane	04/04/2013	
1484	ANW956	2002	Toyota Hiace People Mover	445-2030	27,Sutherland Rd.		31/05/2018
1485	ANW960	2002	Toyota Hiace People Mover	445-2030	27,Sutherland Rd.		31/05/2018
1489	AME361	2002	Toyota Hiace	430-5631	Greenlane Hospital	26/03/2008	
1501	DWW348	2007	Mitsubishi L300	445-4637	218,Gt.South Road	12/06/2007	
1502	DZS404	2007	Hyundai Getz	410-4223	54,Carrington Rd.	29/06/2007	
1503	EAQ333	2007	Mitsubishi Fuso Cantor	430-6001	Auckland Hospital	26/07/2007	
1505	ECM799	2007	Hyundai Getz Auto 1.4L	445-4626	Panmure	05/09/2007	
1507	ECT993	2007	Hyundai Getz Auto 1.4L	445-4505	Greenlane	06/09/2007	
1509	EDR81	2007	Hyundai Getz	445-2028	Auckland Hospital	09/10/2007	
1510	EDR79	2007	Hyundai Getz	445-4627	Morningside		31/05/2018
1512	EDR77	2007	Hyundai Getz	445-4634	Manawanui	09/10/2007	
1513	EDR76	2007	Hyundai Getz	445-4634	Manawanui	09/10/2007	
1514	EDR75	2007	Hyundai Getz	445-4634	Manawanui	09/10/2007	
1515	EDR70	2007	Hyundai Getz	445-4636	27,Sutherland Rd.	08/10/2007	
1520	EDT377	2007	Nissan Wingroad SW	450-6009	Auckland Hospital	11/10/2007	
1521	EFK553	2007	Hyundai Getz	445-4635	Greenlane	10/12/2007	
1522	EFK552	2007	Hyundai Getz	445-4635	Greenlane	10/12/2007	
1524	ETW467	2008	Hyundai Getz	445-4637	Greenlane	13/02/2008	
1526	EJR581	2008	Hyundai Getz	455-8514	Greenlane	20/03/2008	
1527	EJR580	2008	Hyundai Getz	455-8514	Greenlane	20/03/2008	
1529	EKG735	2008	Hyundai Getz	455-8514	Greenlane	28/03/2008	
1531	EKG732	2008	Hyundai Getz	445-4636	Morningside		
1532	EKG739	2008	Hyundai Getz	455-8514	Greenlane	28/03/2008	
1533	EKG729	2008	Hyundai Getz	445-2030	27,Sutherland Rd.	17/03/2008	
1534	EKG730	2008	Hyundai Getz	445-2030	27,Sutherland Rd.		31/05/2018
1535	FRC403	2008	Hyundai Getz	445-2030	27,Sutherland Rd.	31/03/2008	
1538	EKC672	2008	Nissan Urvan Auto	410-4227	Greenlane	18/03/2008	
1540	EKC642	2008	Nissan Wingroad S/W	410-4223	54,Carrington Rd	12/03/2008	
1541	EKC679	2008	Nissan Wingroad	420-4246	Greenlane	20/03/2008	

1542	EKC680	2008	Nissan Wingroad	430-5343	Auckland Hospital	19/03/2008	
Fleet Number	Registration Number	Year of Manufacture	Make and model	Cost Centre	Location	Start date	De-commissioned
1543	EKG733	2008	Hyundai Getz	455-8514	Greenlane	28/03/2008	
1545	ELH286	2008	Hyundai Getz	445-4633	Taylor Centre	02/04/2008	
1547	ELH288	2008	Hyundai Getz	410-4223	Pt.Chevalier	21/04/2008	
1548	ELH295	2008	Hyundai Getz	410-3636	Greenlane	02/04/2008	
1550	ELK655	2008	Nissan Wingroad	410-4227	Greenlane	15/04/2008	
1551	EKC537	2008	Holden Viva S/W	430-6001	Auckland Hospital		15/11/2017
1552	EKC538	2008	Holden Viva S/W	430-6001	Auckland Hospital	16/04/2008	
1553	EKC540	2008	Holden Viva S/W	430-6001	Auckland Hospital	16/04/2008	
1554	EKC539	2008	Holden Viva S/W	430-6001	Auckland Hospital	17/04/2008	
1555	ELT798	2008	Hyundai Getz	445-4634	Manawanui	29/04/2008	
1556	EMD901	2008	Nissan Wingroad	410-4227	Greenlane	19/05/2008	
1557	EMD902	2008	Nissan Wingroad	410-4227	Greenlane	15/05/2008	
1558	EMD903	2008	Nissan Wingroad	410-4227	Greenlane	19/05/2008	
1559	EMD904	2008	Nissan Wingroad	410-4227	Greenlane	20/05/2008	
1560	EMD905	2008	Nissan Wingroad	410-4227	Greenlane	20/05/2008	
1561	EMD906	2008	Nissan Wingroad	410-4227	Greenlane	20/05/2008	
1562	EMD907	2008	Nissan Wingroad	410-4227	Greenlane	22/05/2008	
1563	EMD908	2008	Nissan Wingroad	410-4227	Greenlane	22/05/2008	
1564	EMD909	2008	Nissan Wingroad	410-4227	Greenlane	22/05/2008	
1565	EMD910	2008	Nissan Wingroad	410-4227	Greenlane	23/05/2008	
1566	EMY213	2008	Hyundai Getz	415-3646	Greenlane	13/06/2008	
1567	EMY209	2008	Hyundai Getz	415-2020	Auckland Hospital	12/06/2008	
1571	EPL469	2008	Ford Transit T350	420-4246	Greenlane	06/08/2008	
1572	ERK450	2008	Hyundai Getz	420-4246	Greenlane	29/09/2008	
1573	ERK449	2008	Hyundai Getz	420-4246	Greenlane	29/09/2008	
1574	ERK448	2008	Hyundai Getz	420-4246	Greenlane	29/09/2008	
1575	ERK447	2008	Hyundai Getz	420-4246	Greenlane	29/09/2008	
1576	ERP983	2008	Hyundai Getz	420-4246	Greenlane	08/10/2008	
1577	ERR110	2008	Nissan Wingroad	420-4246	Greenlane	15/10/2008	
1579	ETS866	2009	Nissan Wingroad	420-4246	Greenlane	01/07/2011	
1580	ETS865	2009	Nissan Wingroad	420-4246	Greenlane	22/03/2011	
1582	ETS863	2009	Nissan Urvan	430-5343	Auckland Hospital	22/03/2011	
1584	EYK555	2009	Hyundai Getz	455-8514	Greenlane	23/04/2009	
1585	EYK598	2009	Hyundai Getz	420-4246	Greenlane	21/04/2009	
1586	EYK551	2009	Hyundai Getz	445-4635	Manawanui	23/04/2009	
1587	EYK600	2009	Hyundai Getz	445-4633	Taylor Centre - Waiheke	22/04/2009	
1588	EYK599	2009	Hyundai Getz	445-4633	Taylor Centre	21/04/2009	
1589	EYK550	2009	Hyundai Getz	455-8514	Greenlane	27/04/2009	
1590	EYK558	2009	Hyundai Getz	445-4633	Taylor Centre	26/04/2009	
1592	EYK553	2009	Hyundai Getz	455-8514	Greenlane	24/04/2009	
1595	EYK554	2009	Hyundai Getz	455-8514	Greenlane	24/04/2009	
1597	EYU96	2009	Hyundai Getz	420-4246	Greenlane	13/05/2009	
1600	EYU99	2009	Hyundai Getz	420-4246	Greenlane	13/05/2009	
1602	EZJ559	2009	Hyundai Getz	455-8514	Greenlane	21/05/2009	
1603	EZJ560	2009	Hyundai Getz	410-4223	54,Carrington Rd.	18/05/2009	

1605	EZJ562	2009	Hyundai Getz	455-8514	Greenlane	19/05/2009	
Fleet Number	Registration Number	Year of Manufacture	Make and model	Cost Centre	Location	Start date	De-commissioned
1609	EZJ566	2009	Hyundai Getz	420-4246	Greenlane	19/05/2009	
1610	EZD602	2009	Nissan Wingroad	410-4227	Greenlane	08/06/2009	
1611	EZU776	2009	Hyundai Getz	445-4505	Greenlane	11/06/2009	
1612	EZU777	2009	Hyundai Getz	410-4227	Greenlane	12/06/2009	
1613	EZU778	2009	Hyundai Getz	410-4227	Greenlane	11/06/2009	
1614	EZU779	2009	Hyundai Getz	410-4227	Greenlane	11/06/2009	
1615	FAC249	2009	Hyundai Getz	445-4626	Panmure	07/07/2009	
1616	FAC250	2009	Hyundai Getz	410-4222	Greenlane		11/04/2018
1617	FAC251	2009	Hyundai Getz	445-4627	Morningside	07/07/2009	
1618	FAC252	2009	Hyundai Getz	445-4637	Greenlane	09/07/2009	
1619	FAC253	2009	Hyundai Getz	445-4637	Greenlane	09/07/2009	
1620	FAC254	2009	Hyundai Getz	445-4637	Greenlane	03/07/2009	
1621	FAL581	2009	Hyundai Getz	445-4628	Greenlane	03/07/2009	
1622	FAU41	2009	Hyundai Getz	410-4227	Greenlane	10/07/2009	
1623	FAU61	2009	Hyundai Getz	410-4227	Greenlane	17/07/2009	
1624	FAU62	2009	Hyundai Getz	410-4227	Greenlane	17/07/2009	
1625	FAU63	2009	Hyundai Getz	410-4227	Greenlane	16/07/2009	
1626	FAU64	2009	Hyundai Getz	410-4227	Greenlane	17/07/2009	
1627	FAU65	2009	Hyundai Getz	410-4227	Greenlane	20/07/2009	
1628	FAU66	2009	Hyundai Getz	410-4227	Greenlane	20/07/2009	
1630	FAU68	2009	Hyundai Getz	410-4227	Greenlane	21/07/2009	
1631	FAU69	2009	Hyundai Getz	410-4227	Greenlane	21/07/2009	
1632	FAU70	2009	Hyundai Getz	410-4227	Greenlane	23/07/2009	
1633	FAU71	2009	Hyundai Getz	410-4227	Greenlane	23/07/2009	
1634	FBU225	2009	Hyundai i30 Auto	420-4246	Greenlane	28/08/2009	
1635	FBU226	2009	Hyundai Getz	410-4227	Greenlane	25/08/2009	
1636	FBU227	2009	Hyundai Getz	410-4227	Greenlane	28/08/2009	
1637	FBU228	2009	Hyundai Getz	410-4227	Greenlane	28/08/2009	
1638	FBU229	2009	Hyundai Getz	410-4227	Greenlane	27/08/2009	
1639	FBU233	2009	Hyundai Tuscon AWD	455-8514	Greenlane	24/08/2009	
1640	FEL649	2010	Mercedes Benz Sprinter	450-8915	Greenlane	19/01/2010	
1641	FFL670	2010	Hyundai i30 SW Auto.	430-5631	Auckland Hospital	02/02/2010	
1642	FFC632	2010	Mercedes Benz Sprinter	450-8915	Sylvia Park	20/01/2010	
1644	FKS996	2010	Hyundai Getz	415-3646	Auckland Hospital	08/07/2010	
1645	FKS995	2010	Hyundai Getz	415-3646	Greenlane	08/07/2010	
1646	FKS994	2010	Hyundai Getz	445-4635	Greenlane	06/07/2010	
1647	FKS993	2010	Hyundai Getz	420-4237	Auckland Hospital	06/07/2010	
1648	FKS992	2010	Hyundai Getz	445-4637	Greenlane	07/07/2010	
1649	FML964	2010	Mercedes Benz Sprinter	450-8915	Avondale	06/09/2010	
1650	FQB564	2010	Hyundai Getz	410-4227	Greenlane	18/11/2010	
1652	FQB566	2010	Hyundai Getz	410-4227	Greenlane	18/11/2010	
1653	FQB567	2010	Hyundai Getz	455-8514	Greenlane	18/11/2010	
1654	FQB568	2010	Hyundai Getz	410-4222	Greenlane	18/11/2010	
1655	FQB569	2010	Hyundai Getz	445-4626	Panmure	18/11/2010	
1656	FQB570	2010	Hyundai Getz	445-4627	Morningside	18/11/2010	
1658	FQB572	2010	Hyundai Getz	445-4643	Morningside	18/11/2010	

1659	FQB573	2010	Hyundai Getz	445-4633	Taylor Centre	18/11/2010	
1660	FQB574	2010	Hyundai Getz	445-4635	Greenlane	18/11/2010	
1661	FQB575	2010	Hyundai Getz	445-4635	Greenlane	18/11/2010	
1662	FRP511	2010	Hyundai Getz	445-4633	Waiheke Isl	02/12/2010	
Fleet Number	Registration Number	Year of Manufacture	Make and model	Cost Centre	Location	Start date	De-commissioned
1664	FRP513	2010	Hyundai Getz	420-4246	Greenlane	02/12/2010	
1665	FRP514	2010	Hyundai Getz	420-4246	Greenlane	02/12/2010	
1666	FRP515	2010	Hyundai Getz	420-4246	Greenlane	02/12/2010	
1667	FRP516	2010	Hyundai Getz	420-4246	Greenlane	02/12/2010	
1668	FRP517	2010	Hyundai Getz	420-4246	Greenlane	02/12/2010	
1669	FRP518	2010	Hyundai Getz	420-4246	Greenlane	02/12/2010	
1670	FRP519	2010	Hyundai Getz	445-4625	Greenlane	02/12/2010	
1671	FRP520	2010	Hyundai Getz	445-4625	Greenlane		
1672	FRP522	2010	Hyundai Getz	445-4625	Greenlane	02/12/2010	
1673	FRP521	2010	Hyundai Getz	445-4626	Panmure	02/12/2010	
1674	FSK20	2011	Hyundai Getz	410-4227	Greenlane	30/12/2010	
1675	FSJ991	2011	Hyundai Getz	410-4227	Greenlane	30/12/2010	
1676	FSJ990	2011	Hyundai Getz	420-4246	Greenlane	05/03/2015	
1677	FSJ989	2011	Hyundai Getz	420-4246	Greenlane	30/12/2010	
1678	FSJ988	2011	Hyundai Getz	420-4246	Greenlane	30/12/2010	
1679	FSJ987	2011	Hyundai Getz	420-4246	Greenlane	30/12/2010	
1680	FSJ986	2011	Hyundai Getz	420-4246	Greenlane	30/12/2010	
1681	FSJ985	2011	Hyundai Getz	420-4246	Greenlane	30/12/2010	
1682	FSJ984	2011	Hyundai Getz	445-4627	Morningside	30/12/2010	
1683	FSJ983	2011	Hyundai Getz	445-4627	Morningside	30/12/2010	
1684	FSJ982	2011	Hyundai Getz	445-4633	Taylor Centre	30/12/2010	
1685	FSJ981	2011	Hyundai Getz	445-4633	Taylor Centre	30/12/2010	
1686	FTD104	2011	Hyundai Getz	410-4227	Greenlane	26/01/2011	
1688	FTD89	2011	Hyundai Getz	410-4227	Greenlane	26/01/2011	
1689	FTD90	2011	Hyundai Getz	410-4227	Greenlane	26/01/2011	
1690	FTD91	2011	Hyundai Getz	410-4227	Greenlane	26/01/2011	
1691	FTD92	2011	Hyundai Getz	410-4223	Pt.Chevalier	26/01/2011	
1692	FTD93	2011	Hyundai Getz	410-4227	Greenlane	26/01/2011	
1693	FTD94	2011	Hyundai Getz	420-4246	Greenlane	26/01/2011	
1694	FTD95	2011	Hyundai Getz	420-4246	Greenlane	26/01/2011	
1695	FTD96	2011	Hyundai Getz	420-4246	Greenlane	26/01/2011	
1696	FTD97	2011	Hyundai Getz	420-4246	Greenlane	26/01/2011	
1697	FTD98	2011	Hyundai Getz	445-4626	Panmure	26/01/2011	
1698	FTD99	2011	Hyundai Getz	445-4626	Panmure	26/01/2011	
1699	FTD100	2011	Hyundai Getz	445-4626	Panmure	26/01/2011	
1700	FUL166	2011	Hyundai i30 S/W	410-4227	Greenlane	09/05/2011	
1701	FUL167	2011	Hyundai i30 S/W	410-4227	Greenlane	09/05/2011	
1702	FUL165	2011	Hyundai i30 S/W	420-4246	Greenlane	09/05/2011	
1703	FYC70	2011	Hyundai Getz	445-4647	Hapai Ora	18/05/2011	
1704	FYC71	2011	Hyundai Getz	445-4627	Morningside	16/05/2011	
1705	FYC72	2011	Hyundai Getz	445-4627	Morningside	19/05/2011	
1706	FYC73	2011	Hyundai Getz	445-4627	Morningside	19/05/2011	
1707	FYC74	2011	Hyundai Getz	445-4627	Morningside	13/05/2011	
1709	FYC75	2011	Hyundai Getz	445-4633	Taylor Centre	04/05/2011	
1710	FYC77	2011	Hyundai Getz	445-4635	Greenlane	17/05/2011	
1711	FYC78	2011	Hyundai Getz	445-4635	Greenlane	17/05/2011	
1712	FYC79	2011	Hyundai Getz	415-3646	Greenlane	18/05/2011	
1713	FYC80	2011	Hyundai Getz	415-3646	Greenlane	18/05/2011	
1714	FYC81	2011	Hyundai Getz	430-6001	Greenlane	12/05/2011	

1715	FWM180	2011	Mercedes Benz Sprinter	450-8915	Sylvia Park	30/05/2011	
1716	GCH831	2011	Hyundai i20	445-4625	Greenlane		31/05/2018
1717	GCH832	2011	Hyundai i20	445-4625	Greenlane	08/11/2011	
1718	GCH833	2011	Hyundai i20	410-4227	Greenlane	31/10/2011	
Fleet Number	Registration Number	Year of Manufacture	Make and model	Cost Centre	Location	Start date	De-commissioned
1719	GCH834	2011	Hyundai i20	410-4227	Greenlane	01/11/2011	
1720	GCH835	2011	Hyundai i20	410-4227	Greenlane	01/11/2011	
1721	GCH836	2011	Hyundai i20	410-4227	Greenlane	01/11/2011	
1722	GCH842	2011	Hyundai i20	410-4227	Greenlane	28/10/2011	
1723	GCH843	2011	Hyundai i20	410-4227	Greenlane	08/11/2011	
1724	GCH844	2011	Hyundai i20	410-4227	Greenlane	31/10/2011	
1725	GCH845	2011	Hyundai i20	410-4227	Greenlane	05/11/2011	
1727	GFP410	2012	Hyundai i20 Auto	410-4227	Greenlane	17/02/2012	
1728	GFP405	2012	Hyundai i20 Auto	410-4227	Greenlane	17/02/2012	
1729	GFP408	2012	Hyundai i20 Auto	410-4227	Greenlane	17/02/2012	
1730	GFP406	2012	Hyundai i20 Auto	410-4227	Greenlane	21/02/2012	
1731	GFP404	2012	Hyundai i20 Auto	410-4227	Greenlane	21/02/2012	
1732	GFP403	2012	Hyundai i20 Auto	410-4227	Greenlane	21/02/2012	
1733	GFP409	2012	Hyundai i20 Auto	410-4227	Greenlane	21/02/2012	
1734	GFP401	2012	Hyundai i20 Auto	410-4227	Greenlane	21/02/2012	
1735	GFP402	2012	Hyundai i20	420-4246	Greenlane	17/02/2012	
1736	GFP407	2012	Hyundai i20 Auto	420-4246	Greenlane	16/02/2012	
1744	GGZ920	2012	Hyundai i20 Auto	410-4227	Greenlane	28/03/2012	
1745	GHT500	2012	Mercedes Benz Sprinter	450-8915	Greenlane	21/05/2012	
1746	GJN182	2012	Mercedes Benz Sprinter	450-8915	Sandringham	12/06/2012	
1747	GPF169	2012	Toyota Hilux 3.0.TD	455-8514	Greenlane	24/10/2012	
1758	EUJ794	2008	Hyundai Getz	445-4633	Taylor Centre	07/05/2013	
1759	EUW326	2009	Hyundai Getz	445-4633	Taylor Centre	03/05/2013	
1760	FAC255	2009	Hyundai Getz	430-6001	Greenlane	03/05/2013	
1761	EYK584	2009	Hyundai Getz	430-6001	Greenlane Hospital	03/05/2013	
1762	EWZ916	2009	Hyundai Getz	420-4246	Greenlane	03/05/2013	
1763	EWL470	2009	Hyundai Getz	420-4246	Greenlane	03/05/2013	
1764	EUJ792	2008	Hyundai Getz	420-4241	Greenlane	03/05/2013	
1765	FDH159	2009	Hyundai Getz	420-4241	Greenlane	03/05/2013	
1766	EWZ911	2009	Hyundai Getz	420-4241	Greenlane		11/08/2017
1767	KDC795	2013	Hyundai Imax 8 seat	445-4634	Manawanui	27/05/2013	
1768	GUZ903	2013	Hyundai i20 5D H/B	420-4241	Greenlane	30/05/2013	
1769	GUZ904	2013	Hyundai i20 Automatic	445-4625	Greenlane	12/06/2013	
1770	GUZ905	2013	Hyundai i20 Automatic	445-4625	Greenlane	12/06/2013	
1771	GUZ906	2013	Hyundai i20 Automatic	445-4625	Greenlane	12/06/2013	
1772	GUZ907	2013	Hyundai i29 Auto H/B	420-4246	Greenlane	29/05/2013	
1773	GUZ908	2013	Hyundai i20 Auto	415-2020	Auckland Hospital	17/06/2013	
1774	GUZ909	2013	Hyundai i20 Auto H/B	445-4633	Taylor Centre	28/05/2013	

1775	GUZ910	2013	Hyundai i20 Auto H/B	445-4633	Taylor Centre	28/05/2013	
1776	GUZ911	2013	Hyundai i20 Automatic	420-3111	Grafton	14/06/2013	
1778	GUZ913	2013	Hyundai i20 Auto H/B	415-3646	Greenlane	30/05/2013	
Fleet Number	Registration Number	Year of Manufacture	Make and model	Cost Centre	Location	Start date	De-commissioned
1779	GUZ914	2013	Hyundai i20 Auto H/B	415-3646	Greenlane	30/05/2013	
1780	GUZ915	2013	Hyundai i20 Automatic	410-4227	Greenlane	18/06/2013	
1781	GUZ916	2013	Hyundai i20 Automatic	410-4227	Greenlane	18/06/2013	
1782	GUZ917	2013	Hyundai i20 Automatic	410-4227	Greenlane	18/06/2013	
1783	GWT179	2013	Hyundai i20 Auto	445-4647	Greenlane	13/06/2013	
1784	GWN703	2013	Toyota Corolla S/W	445-4637	Greenlane	13/06/2013	
1785	HCY633	2013	Hyundai Accent	410-4226	Auckland Hospital	05/11/2013	
1786	HCY632	2013	Hyundai Accent	445-4627	Morningside	06/11/2013	
1787	HFP234	2014	Holden Cruze S/W Auto	420-4246	Greenlane	24/01/2014	
1788	HFP233	2014	Holden Cruze S/W Auto	420-4246	Greenlane	24/01/2014	
1789	HFP235	2014	Holden Cruze 1.8 S/W	410-4223	54,Carrington Rd.	30/01/2014	
1790	HFP236	2014	Holden Cruze 1.8 S/W	410-4223	54,Carrington Rd.	30/01/2014	
1791	HFP237	2014	Holden Cruze 1.8 S/W	410-4223	54,Carrington Rd.	30/01/2014	
1792	HFP238	2014	Holden Cruze 1.8 S/W	410-4223	54,Carrington Rd.	28/01/2014	
1793	HFP239	2014	Holden Cruze 1.8 S/W	410-4223	54,Carrington Rd.	31/01/2014	
1794	HFP240	2014	Holden Cruze 1.8 S/W	410-4223	54,Carrington Rd.	31/01/2014	
1795	HFG156	2014	Hyundai i20 5DHB	410-4227	Greenlane	10/01/2014	
1796	HHL489	2014	Holden Cruze 1.8 S/W	410-4223	54,Carrington Rd.	13/03/2014	
1797	HHL491	2014	Holden Cruze 1.8 S/W	410-4223	54,Carrington Rd.	13/03/2014	
1798	HHL492	2014	Holden Cruze 1.8 S/W	410-4222	Greenlane	18/03/2014	
1799	FQB571	2010	Hyundai Getz	445-4625	Greenlane	18/11/2010	
1800	JGR998	2014	Holden Cruze 1.8 S/W	445-4643	Morningside	13/03/2014	
1801	HHL493	2014	Holden Cruze 1.8 S/W	445-4643	Morningside	20/03/2014	
1802	HHL494	2014	Holden Cruze 1.8 S/W	445-4639	Greenlane	18/03/2014	
1803	HHL495	2014	Holden Cruze 1.8 S/S	420-4233	Greenlane	17/03/2014	
1804	HHL496	2014	Holden Cruze 1.8 S/W	445-4639	Greenlane	18/03/2014	
1805	HHL497	2014	Holden Cruze 1.8 S/W	445-4633	Taylor Centre	19/03/2014	
1806	HJH715	2014	Hyundai Accent 5DHB	410-4227	Greenlane	11/04/2014	

1807	HJH720	2014	Hyundai Accent 5DHB	410-4227	Greenlane	11/04/2014	
1808	HJH717	2014	Hyundai I20 5DHB	410-4227	Greenlane	11/04/2014	
1809	HJH719	2014	Hyundai Accent 5DHB	445-4505	Greenlane	16/04/2014	
Fleet Number	Registration Number	Year of Manufacture	Make and model	Cost Centre	Location	Start date	De-commissioned
1810	HJH716	2014	Hyundai Accent 5DHB	445-4633	Taylor Centre	14/04/2014	
1811	HJH718	2014	Hyundai Accent 5DHB	410-3044	Greenlane	14/04/2014	
1820	HLM80	2014	Mercedes Benz Sprinter	420-4246	Greenlane	01/07/2014	
1821	HNF128	2014	Mercedes Benz Sprinter	420-4246	Greenlane	20/08/2014	
1822	HPA212	2014	Hyundai Accent	445-4635	Greenlane	20/08/2014	
1823	HPA251	2014	Hyundai I20	445-4635	Greenlane	20/08/2014	
1824	HPA252	2014	Hyundai I20	420-4246	Greenlane	19/08/2014	
1825	HPA253	2014	Hyundai I20	420-4246	Greenlane	20/08/2014	
1826	HPA249	2014	Hyundai I20	410-4227	Greenlane	21/08/2014	
1827	HPA250	2014	Hyundai I20	410-4227	Greenlane	21/08/2014	
1828	HPA247	2014	Hyundai I20	445-4643	Morningside	14/08/2014	
1829	HPA248	2014	Hyundai I20	445-4643	Morningside	18/08/2014	
1830	HPA213	2014	Hyundai Accent	445-4626	Panmure	14/08/2014	
1832	HQR871	2014	Holden Cruze SW	430-5019	Mt.Wellington		
1833	HYP346	2015	Hyundai I20 Auto	410-4227	Greenlane	17/02/2015	
1834	HUY669	2015	Toyota HiAce ZL	430-5631	Auckland Hospital	15/01/2015	
1835	HUM833	2015	Holden Cruze 1.8L S/W	445-4627	Morningside	12/02/2015	
1836	HWA476	2015	Hyundai Accent	445-4627	Morningside	09/01/2015	
1837	HWA471	2015	Hyundai I20	445-4627	Morningside	09/01/2015	
1838	HWA474	2015	Hyundai I20	445-4627	Morningside	09/01/2015	
1839	HUM832	2015	Holden Cruze 1.8L S/W	445-4647	Hapai Ora (EIT)	13/02/2015	
1840	HUM831	2015	Holden Cruze 1.8L S/W	445-4635	Greenlane	13/02/2015	
1841	HWA473	2015	Hyundai I20	445-4635	Greenlane	09/01/2015	
1842	HWA470	2015	Hyundai I20	445-4635	Greenlane	09/01/2015	
1843	HWA475	2015	Hyundai Accent	445-4635	Greenlane	09/01/2015	
1844	HYU523	2015	Hyundai I20	410-3636	Greenlane	05/03/2015	
1845	HYU519	2015	Hyundai I20	410-4223	54,Carrington Road	04/03/2015	
1846	HYU520	2015	Hyundai I20	410-4227	Greenlane	03/03/2015	
1847	HYZ774	2015	Holden Barina 1.6	410-4227	Greenlane		16/10/2017
1848	HYZ775	2015	Holden Barina	410-4227	Greenlane	10/03/2015	
1849	HYZ776	2015	Holden Barina 1.6	420-4237	Greenlane	09/03/2015	
1850	HYZ778	2015	Holden Barina 1.6	420-4246	Greenlane	09/03/2015	
1851	HYU521	2015	Hyundai I20	420-4246	Greenlane	03/03/2015	
1852	HYU522	2015	Hyundai I20	420-4246	Greenlane	03/03/2015	
1853	HYZ779	2015	Holden Cruze S/W	420-4246	Greenlane	09/03/2015	
1854	HYU579	2015	Hyundai I20	420-4246	Greenlane	03/03/2015	
1855	JAL365	2015	Holden Cruze	430-5631	Auckland	01/04/2015	

			S/W		Hospital		
1856	JAL367	2015	Holden Cruze S/W	445-2029	Auckland Hospital	01/04/2015	
Fleet Number	Registration Number	Year of Manufacture	Make and model	Cost Centre	Location	Start date	De-commissioned
1860	JAA943	2015	Hyundai i20	445-4626	Panmure	30/03/2015	
1861	JAA945	2015	Hyundai Accent 1.6	445-4639	Greenlane	04/04/2015	
1863	JFT376	2015	Holden Barina 5DHB	445-4647	Hapai Ora, Epsom	10/08/2015	
1864	JFT378	2015	Holden Barina 5DHB	445-4635	Greenlane	11/08/2015	
1865	JGM254	2015	Hyundai i20	445-4626	Panmure	17/08/2015	
1866	JGM255	2015	Hyundai i20	445-4627	Morningside	18/08/2015	
1867	JFT379	2015	Holden Barina 5DHB	445-4627	Morningside	11/08/2015	
1868	JFT380	2015	Holden Cruze 1.8L S/W	445-2028	Grafton	04/08/2015	
1869	JHH448	2015	Hyundai i20	420-4246	Greenlane		11/09/2017
1870	JHH447	2015	Hyundai i20	450-8535	Greenlane		
1871	JKB537	2015	Hyundai i20	445-4505	Greenlane	02/11/2015	
1872	JKB538	2015	Hyundai i20	445-4505	Greenlane	02/11/2015	
1873	JNZ440	2016	Holden Cruze 1.8 S/W	420-4246	Greenlane3	26/01/2016	
1874	JRG267	2016	Hyundai i20	410-4227	Greenlane	30/03/2016	
1875	JRG265	2016	Hyundai i20	420-4246	Greenlane	13/04/2016	
1876	JRG266	2016	Hyundai i20	420-4246	Greenlane	13/04/2016	
1877	JRG273	2016	Hyundai i20	420-4246	Greenlane	13/04/2016	
1878	JRG274	2016	Hyundai i20	420-4246	Greenlane	13/04/2016	
1879	JRG272	2016	Hyundai i20	430-6001	Auckland Hospital	06/04/2016	
1880	JTF797	2016	Holden Cruze 1.8l S/W	445-4639	Greenlane	06/05/2016	
1881	JTF798	2016	Holden Cruze 1.8 S/W	445-4639	Greenlane	06/05/2016	
1882	JTF796	2016	Holden Cruze 1.8 S/W	455-8514	Greenlane	13/05/2016	
1883	JRG268	2016	Hyundai i20	455-8514	Greenlane	05/04/2016	
1884	JTF795	2016	Holden Cruze S.W	455-8514	Greenlane	13/05/2016	
1885	JRG270	2016	Hyundai i20	455-8514	Greenlane	07/04/2016	
1886	JRG278	2016	Hyundai i20	455-8514	Greenlane	07/04/2016	
1887	JRG277	2016	Hyundai i20	455-8514	Greenlane		05/06/2018
1888	JRG271	2016	Hyundai i20	455-8514	Greenlane	05/04/2016	
1889	JRG269	2016	Hyundai i20	455-8514	Greenlane	05/04/2016	
1890	JRG275	2016	Hyundai i20	455-8514	Greenlane	07/04/2016	
1891	JRG276	2016	Hyundai i20	455-8514	Greenlane	05/04/2016	
1892	JTW904	2016	Hyundai i20	455-8514	Greenlane	03/06/2016	
1893	JTW906	2016	Hyundai i20	455-8514	Greenlane	03/06/2016	
1894	JTW907	2016	Hyundai i20	410-4227	Greenlane	01/06/2016	
1895	JTW908	2016	Hyundai i20	410-4227	Greenlane	01/06/2016	
1896	JTW905	2016	Hyundai i20	445-4633	Taylor Centre	24/05/2016	
1897	JUR877	2016	Holden Barina 1.6	415-3646	Greenlane		
1902	KCC39	2016	Holden Barina	445-4637	Greenlane	12/10/2016	

1903	KDL789	2016	Hyundai Imax 8seat	445-4639	Greenlane		
1904	KEF971	2016	Hyundai Imax 8 seat	445-4645	Parnell		
1905	KEK755	2016	Holden Barina	420-4240	Greenlane		
1906	KGL165	2017	Holden Barina	445-4627	Morningside	23/01/2017	
Fleet Number	Registration Number	Year of Manufacture	Make and model	Cost Centre	Location	Start date	De-commissioned
1907	JGH158	2015	Hyundai Accent 5DHB	445-4634	Manawanui	04/08/2015	
1908	LGW734	2018	Toyota Prius C Hybrid	03-410-4223	Rehab Plus	27/04/2018	
1909	LGW732	2018	Toyota Prius C Hybrid	445-4633	Taylor Centre	24/05/2018	
1910	LGW731	2018	Toyota Prius C Hybrid	445-2030	Buchanan Centre	23/05/2018	
1911	LGW729	2018	Toyota Prius C Hybrid	445-2030	Buchanan Centre	23/05/2018	
1912	LGW733	2018	Toyota Prius C Hybrid	445-4647	Epsom	24/05/2018	
1913	LGW759	2018	Toyota Hi Ace Minivan	445-2030	Buchanan Centre	23/05/2018	
1918	LKZ481	2018	Ford Custom Transit	410-4223	Rehab Plus	25/06/2018	

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Fleet Number	Registration Number	Registration Year	Make and model	Cost Centre	Location	Decommissioned
1490	ALQ457	2002	Toyota Hiace ZR	410-4223	54,Carrington Rd.	
1489	AME361	2002	Toyota Hiace ZR	430-5631	Greenlane Hospital	
1484	ANW956	2002	Toyota Hiace ZL	445-2030	27,Sutherland Rd.	
1485	ANW960	2002	Toyota Hiace ZL	445-2030	27,Sutherland Rd.	
1080	BAL235	2002	Toyota Hiace ZX	410-4223	54,Carrington Rd.	
1068	BJU595	2003	Toyota Hiace	445-2031	SSH	
1052	BTJ351	2004	Toyota Hiace ZL	445-4636	Buchanan Clinic	
1355	DNK423	2006	Hyundai Getz	445-4626	Panmure	
1353	DNK424	2006	Hyundai Getz	445-4626	Panmure	
1425	DNU448	2006	Hyundai Getz	415-3646	Greenlane	
1501	DWW348	2007	Mitsubishi L300	445-4637	218,Gt.South Road	
1502	DZS404	2007	Hyundai Getz	410-4223	54,Carrington Rd.	
1503	EAQ333	2007	Mitsubishi Fuso	430-6001	Auckland Hospital	
1505	ECM799	2007	Hyundai Getz	445-4626	Panmure	
1507	ECT993	2007	Hyundai Getz	445-4505	Greenlane	
1515	EDR70	2007	Hyundai Getz	445-4636	27,Sutherland Rd.	
1514	EDR75	2007	Hyundai Getz	445-4634	Manawanui	
1513	EDR76	2007	Hyundai Getz	445-4634	Manawanui	
1512	EDR77	2007	Hyundai Getz	445-4634	Manawanui	
1510	EDR79	2007	Hyundai Getz	445-4627	Morningside	
1509	EDR81	2007	Hyundai Getz	445-2028	Auckland Hospital	

1520	EDT377	2007	Nissan Wingroad S/W	450-6009	Auckland Hospital	
1333	EFG468	2006	Hyundai Getz	445-4633	Waiheke Isl	
1522	EFK552	2007	Hyundai Getz	445-4635	Greenlane	
1521	EFK553	2007	Hyundai Getz	445-4635	Greenlane	
Fleet Number	Registration Number	Registration Year	Make and model	Cost Centre	Location	Decommissioned
1527	EJR580	2008	Hyundai Getz	455-8514	Greenlane	
1526	EJR581	2008	Hyundai Getz	455-8514	Greenlane	
1551	EKC537	2008	Holden Viva S/W	430-6001	Auckland Hospital	15/11/2017
1552	EKC538	2008	Holden Viva S/W	430-6001	Auckland Hospital	
1554	EKC539	2008	Holden Viva S/W	430-6001	Auckland Hospital	
1553	EKC540	2008	Holden Viva S/W	430-6001	Auckland Hospital	
1540	EKC642	2008	Nissan Wingroad S/W	410-4223	54,Carrington Rd	
1538	EKC672	2008	Nissan Urvan	410-4227	Greenlane	
1541	EKC679	2008	Nissan Wingroad S/W	420-4246	Greenlane	
1542	EKC680	2008	Nissan Wingroad S/W	430-5343	Auckland Hospital	
1533	EKG729	2008	Hyundai Getz	445-2030	27,Sutherland Rd.	
1534	EKG730	2008	Hyundai Getz	445-2030	27,Sutherland Rd.	
1531	EKG732	2008	Hyundai Getz	445-4636	Morningside	
1543	EKG733	2008	Hyundai Getz	455-8514	Greenlane	
1530	EKG734	2008	Hyundai Getz	455-8514	Greenlane	06/12/2016
1529	EKG735	2008	Hyundai Getz	455-8514	Greenlane	
1537	EKG736	2008	Hyundai Getz	455-8514	Greenlane	06/12/2016
1532	EKG739	2008	Hyundai Getz	455-8514	Greenlane	
1545	ELH286	2008	Hyundai Getz	445-4633	Taylor Centre	
1547	ELH288	2008	Hyundai Getz	410-4223	Pt.Chevalier	
1548	ELH295	2008	Hyundai Getz	410-3636	Greenlane	
1550	ELK655	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1555	ELT798	2008	Hyundai Getz	445-4634	Manawanui	
1556	EMD901	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1557	EMD902	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1558	EMD903	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1559	EMD904	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1560	EMD905	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1561	EMD906	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1562	EMD907	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1563	EMD908	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1564	EMD909	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1565	EMD910	2008	Nissan Wingroad S/W	410-4227	Greenlane	

1567	EMY209	2008	Hyundai Getz	415-2020	Auckland Hospital	
1569	EMY211	2008	Hyundai Getz	445-4643	Morningside	27/03/2017
1566	EMY213	2008	Hyundai Getz	415-3646	Greenlane	
1571	EPL469	2008	Ford Transit	420-4246	Greenlane	
Fleet Number	Registration Number	Registration Year	Make and model	Cost Centre	Location	Decommissioned
1575	ERK447	2008	Hyundai Getz	420-4246	Greenlane	
1574	ERK448	2008	Hyundai Getz	420-4246	Greenlane	
1573	ERK449	2008	Hyundai Getz	420-4246	Greenlane	
1572	ERK450	2008	Hyundai Getz	420-4246	Greenlane	
1576	ERP983	2008	Hyundai Getz	420-4246	Greenlane	
1577	ERR110	2008	Nissan Wingroad S/W	420-4246	Greenlane	
1582	ETS863	2009	Nissan Urvan	430-5343	Auckland Hospital	
1580	ETS865	2009	Nissan Wingroad S/W	420-4246	Greenlane	
1579	ETS866	2009	Nissan Wingroad S/W	420-4246	Greenlane	
1524	ETW467	2008	Hyundai Getz	445-4637	Greenlane	
1764	EUJ792	2008	Hyundai Getz	420-4241	Greenlane	
1758	EUJ794	2008	Hyundai Getz	445-4633	Taylor Centre	
1759	EUW326	2009	Hyundai Getz	445-4633	Taylor Centre	
1763	EWL470	2009	Hyundai Getz	420-4246	Greenlane	
1766	EWZ911	2009	Hyundai Getz	420-4241	Greenlane	11/08/2017
1762	EWZ916	2009	Hyundai Getz	420-4246	Greenlane	
1589	EYK550	2009	Hyundai Getz	455-8514	Greenlane	
1586	EYK551	2009	Hyundai Getz	445-4635	Manawanui	
1592	EYK553	2009	Hyundai Getz	455-8514	Greenlane	
1595	EYK554	2009	Hyundai Getz	455-8514	Greenlane	
1584	EYK555	2009	Hyundai Getz	455-8514	Greenlane	
1593	EYK557	2009	Hyundai Getz	455-8514	Greenlane	05/09/2016
1590	EYK558	2009	Hyundai Getz	445-4633	Taylor Centre	
1761	EYK584	2009	Hyundai Getz	430-6001	Greenlane Hospital	
1585	EYK598	2009	Hyundai Getz	420-4246	Greenlane	
1588	EYK599	2009	Hyundai Getz	445-4633	Taylor Centre	
1587	EYK600	2009	Hyundai Getz	445-4633	Taylor Centre	
1596	EYU95	2009	Hyundai Getz	455-8514	Greenlane	06/12/2016
1597	EYU96	2009	Hyundai Getz	420-4246	Greenlane	
1600	EYU99	2009	Hyundai Getz	420-4246	Greenlane	
1610	EZD602	2009	Nissan Wingroad S/W	410-4227	Greenlane	
1601	EZD903	2009	Hyundai Getz	455-8514	Greenlane	06/12/2016
1602	EZJ559	2009	Hyundai Getz	455-8514	Greenlane	
1603	EZJ560	2009	Hyundai Getz	410-4223	54,Carrington Rd.	
1605	EZJ562	2009	Hyundai Getz	455-8514	Greenlane	
1607	EZJ564	2009	Hyundai Getz	455-8514	Greenlane	06/12/2016
1609	EZJ566	2009	Hyundai Getz	420-4246	Greenlane	
1611	EZU776	2009	Hyundai Getz	445-4505	Greenlane	

1612	EZU777	2009	Hyundai Getz	410-4227	Greenlane	
1613	EZU778	2009	Hyundai Getz	410-4227	Greenlane	
1614	EZU779	2009	Hyundai Getz	410-4227	Greenlane	
1615	FAC249	2009	Hyundai Getz	445-4626	Panmure	
Fleet Number	Registration Number	Registration Year	Make and model	Cost Centre	Location	Decommissioned
1616	FAC250	2009	Hyundai Getz	410-4222	Greenlane	
1617	FAC251	2009	Hyundai Getz	445-4627	Morningside	
1618	FAC252	2009	Hyundai Getz	445-4637	Greenlane	
1619	FAC253	2009	Hyundai Getz	445-4637	Greenlane	
1620	FAC254	2009	Hyundai Getz	445-4637	Greenlane	
1760	FAC255	2009	Hyundai Getz	430-6001	Greenlane	
1621	FAL581	2009	Hyundai Getz	445-4628	Greenlane	
1622	FAU41	2009	Hyundai Getz	410-4227	Greenlane	
1623	FAU61	2009	Hyundai Getz	410-4227	Greenlane	
1624	FAU62	2009	Hyundai Getz	410-4227	Greenlane	
1625	FAU63	2009	Hyundai Getz	410-4227	Greenlane	
1626	FAU64	2009	Hyundai Getz	410-4227	Greenlane	
1627	FAU65	2009	Hyundai Getz	410-4227	Greenlane	
1628	FAU66	2009	Hyundai Getz	410-4227	Greenlane	
1630	FAU68	2009	Hyundai Getz	410-4227	Greenlane	
1631	FAU69	2009	Hyundai Getz	410-4227	Greenlane	
1632	FAU70	2009	Hyundai Getz	410-4227	Greenlane	
1633	FAU71	2009	Hyundai Getz	410-4227	Greenlane	
1634	FBU225	2009	Hyundai i30 Auto	420-4246	Greenlane	
1635	FBU226	2009	Hyundai Getz	410-4227	Greenlane	
1636	FBU227	2009	Hyundai Getz	410-4227	Greenlane	
1637	FBU228	2009	Hyundai Getz	410-4227	Greenlane	
1638	FBU229	2009	Hyundai Getz	410-4227	Greenlane	
1639	FBU233	2009	Hyundai Tuscon AWD	455-8514	Greenlane	
1765	FDH159	2009	Hyundai Getz	420-4241	Greenlane	
1640	FEL649	2010	Mercedes Benz Sprinter	450-8915	Greenlane	
1642	FFC632	2010	Mercedes Benz Sprinter	450-8915	Sylvia Park	
1641	FFL670	2010	Hyundai i30 S/W	430-5631	Auckland Hospital	
1648	FKS992	2010	Hyundai Getz	445-4637	Greenlane	
1647	FKS993	2010	Hyundai Getz	420-4237	Auckland Hospital	
1646	FKS994	2010	Hyundai Getz	445-4635	Greenlane	
1645	FKS995	2010	Hyundai Getz	415-3646	Greenlane	
1644	FKS996	2010	Hyundai Getz	415-3646	Auckland Hospital	
1649	FML964	2010	Mercedes Benz Sprinter	450-8915	Avondale	
1650	FQB564	2010	Hyundai Getz	410-4227	Greenlane	
1652	FQB566	2010	Hyundai Getz	410-4227	Greenlane	
1653	FQB567	2010	Hyundai Getz	455-8514	Greenlane	
1654	FQB568	2010	Hyundai Getz	410-4222	Greenlane	

1655	FQB569	2010	Hyundai Getz	445-4626	Panmure	
1656	FQB570	2010	Hyundai Getz	445-4627	Morningside	
1799	FQB571	2010	Hyundai Getz	445-4625	Greenlane	
1658	FQB572	2010	Hyundai Getz	445-4643	Morningside	
Fleet Number	Registration Number	Registration Year	Make and model	Cost Centre	Location	Decommissioned
1659	FQB573	2010	Hyundai Getz	445-4633	Taylor Centre	
1660	FQB574	2010	Hyundai Getz	445-4635	Greenlane	
1661	FQB575	2010	Hyundai Getz	445-4635	Greenlane	
1535	FRC403	2008	Hyundai Getz	445-2030	27,Sutherland Rd.	
1662	FRP511	2010	Hyundai Getz	445-4633	Waiheke Isl	
1664	FRP513	2010	Hyundai Getz	420-4246	Greenlane	
1665	FRP514	2010	Hyundai Getz	420-4246	Greenlane	
1666	FRP515	2010	Hyundai Getz	420-4246	Greenlane	
1667	FRP516	2010	Hyundai Getz	420-4246	Greenlane	
1668	FRP517	2010	Hyundai Getz	420-4246	Greenlane	
1669	FRP518	2010	Hyundai Getz	420-4246	Greenlane	
1670	FRP519	2010	Hyundai Getz	445-4625	Greenlane	
1671	FRP520	2010	Hyundai Getz	445-4625	Greenlane	
1673	FRP521	2010	Hyundai Getz	445-4626	Panmure	
1672	FRP522	2010	Hyundai Getz	445-4625	Greenlane	
1685	FSJ981	2011	Hyundai Getz	445-4633	Taylor Centre	
1684	FSJ982	2011	Hyundai Getz	445-4633	Taylor Centre	
1683	FSJ983	2011	Hyundai Getz	445-4627	Morningside	
1682	FSJ984	2011	Hyundai Getz	445-4627	Morningside	
1681	FSJ985	2011	Hyundai Getz	420-4246	Greenlane	
1680	FSJ986	2011	Hyundai Getz	420-4246	Greenlane	
1679	FSJ987	2011	Hyundai Getz	420-4246	Greenlane	
1678	FSJ988	2011	Hyundai Getz	420-4246	Greenlane	
1677	FSJ989	2011	Hyundai Getz	420-4246	Greenlane	
1676	FSJ990	2011	Hyundai Getz	420-4246	Greenlane	
1675	FSJ991	2011	Hyundai Getz	410-4227	Greenlane	
1674	FSK20	2011	Hyundai Getz	410-4227	Greenlane	
1699	FTD100	2011	Hyundai Getz	445-4626	Panmure	
1686	FTD104	2011	Hyundai Getz	410-4227	Greenlane	
1688	FTD89	2011	Hyundai Getz	410-4227	Greenlane	
1689	FTD90	2011	Hyundai Getz	410-4227	Greenlane	
1690	FTD91	2011	Hyundai Getz	410-4227	Greenlane	
1691	FTD92	2011	Hyundai Getz	410-4223	Pt.Chevalier	
1692	FTD93	2011	Hyundai Getz	410-4227	Greenlane	
1693	FTD94	2011	Hyundai Getz	420-4246	Greenlane	
1694	FTD95	2011	Hyundai Getz	420-4246	Greenlane	
1695	FTD96	2011	Hyundai Getz	420-4246	Greenlane	
1696	FTD97	2011	Hyundai Getz	420-4246	Greenlane	
1697	FTD98	2011	Hyundai Getz	445-4626	Panmure	
1698	FTD99	2011	Hyundai Getz	445-4626	Panmure	
1702	FUL165	2011	Hyundai i30 S/W	420-4246	Greenlane	

1700	FUL166	2011	Hyundai i30 S/W	410-4227	Greenlane	
1701	FUL167	2011	Hyundai i30 S/W	410-4227	Greenlane	
1715	FWM180	2011	Mercedes Benz Sprinter	450-8915	Sylvia Park	
1703	FYC70	2011	Hyundai Getz	445-4626	Panmure	
Fleet Number	Registration Number	Registration Year	Make and model	Cost Centre	Location	Decommissioned
1704	FYC71	2011	Hyundai Getz	445-4627	Morningside	
1705	FYC72	2011	Hyundai Getz	445-4627	Morningside	
1706	FYC73	2011	Hyundai Getz	445-4627	Morningside	
1707	FYC74	2011	Hyundai Getz	445-4627	Morningside	
1709	FYC75	2011	Hyundai Getz	445-4633	Taylor Centre	
1708	FYC76	2011	Hyundai Getz	445-4627	Morningside	19/10/2016
1710	FYC77	2011	Hyundai Getz	445-4635	Greenlane	
1711	FYC78	2011	Hyundai Getz	445-4635	Greenlane	
1712	FYC79	2011	Hyundai Getz	415-3646	Greenlane	
1713	FYC80	2011	Hyundai Getz	415-3646	Greenlane	
1714	FYC81	2011	Hyundai Getz	430-6001	Greenlane	
1716	GCH831	2011	Hyundai i20	445-4625	Greenlane	
1717	GCH832	2011	Hyundai i20	445-4625	Greenlane	
1718	GCH833	2011	Hyundai i20	410-4227	Greenlane	
1719	GCH834	2011	Hyundai i20	410-4227	Greenlane	
1720	GCH835	2011	Hyundai i20	410-4227	Greenlane	
1721	GCH836	2011	Hyundai i20	410-4227	Greenlane	
1722	GCH842	2011	Hyundai i20	410-4227	Greenlane	
1723	GCH843	2011	Hyundai i20	410-4227	Greenlane	
1724	GCH844	2011	Hyundai i20	410-4227	Greenlane	
1725	GCH845	2011	Hyundai i20	410-4227	Greenlane	
1734	GFP401	2012	Hyundai i20	410-4227	Greenlane	
1735	GFP402	2012	Hyundai i20	420-4246	Greenlane	
1732	GFP403	2012	Hyundai i20	410-4227	Greenlane	
1731	GFP404	2012	Hyundai i20	410-4227	Greenlane	
1728	GFP405	2012	Hyundai i20	410-4227	Greenlane	
1730	GFP406	2012	Hyundai i20	410-4227	Greenlane	
1736	GFP407	2012	Hyundai i20	420-4246	Greenlane	
1729	GFP408	2012	Hyundai i20	410-4227	Greenlane	
1733	GFP409	2012	Hyundai i20	410-4227	Greenlane	
1727	GFP410	2012	Hyundai i20	410-4227	Greenlane	
1744	GGZ920	2012	Hyundai i20	410-4227	Greenlane	
1745	GHT500	2012	Mercedes Benz Sprinter	450-8915	Greenlane	
1746	GJN182	2012	Mercedes Benz Sprinter	450-8915	Sandringham	
1747	GPF169	2012	Toyota Hilux 3.0.TD	455-8514	Greenlane	
1768	GUZ903	2013	Hyundai i20	420-4241	Greenlane	
1769	GUZ904	2013	Hyundai i20	445-4625	Greenlane	
1770	GUZ905	2013	Hyundai i20	445-4625	Greenlane	
1771	GUZ906	2013	Hyundai i20	445-4625	Greenlane	

1772	GUZ907	2013	Hyundai i20	420-4246	Greenlane	
1773	GUZ908	2013	Hyundai i20	415-2020	Auckland Hospital	
1774	GUZ909	2013	Hyundai i20	445-4633	Taylor Centre	
1775	GUZ910	2013	Hyundai i20	445-4633	Taylor Centre	
Fleet Number	Registration Number	Registration Year	Make and model	Cost Centre	Location	Decommissioned
1776	GUZ911	2013	Hyundai i20	420-3111	Grafton	
1778	GUZ913	2013	Hyundai i20	415-3646	Greenlane	
1779	GUZ914	2013	Hyundai i20	415-3646	Greenlane	
1780	GUZ915	2013	Hyundai i20	410-4227	Greenlane	
1781	GUZ916	2013	Hyundai i20	410-4227	Greenlane	
1782	GUZ917	2013	Hyundai i20	410-4227	Greenlane	
1784	GWN703	2013	Toyota Corolla S/W	445-4637	Greenlane	
1783	GWT179	2013	Hyundai i20	445-4637	Greenlane	
1786	HCY632	2013	Hyundai Accent	445-4627	Morningside	
1785	HCY633	2013	Hyundai Accent	410-4226	Auckland Hospital	
1795	HFG156	2014	Hyundai i20	410-4227	Greenlane	
1788	HFP233	2014	Holden Cruze S/W	420-4246	Greenlane	
1787	HFP234	2014	Holden Cruze S/W	420-4246	Greenlane	
1789	HFP235	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1790	HFP236	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1791	HFP237	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1792	HFP238	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1793	HFP239	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1794	HFP240	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1796	HHL489	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1797	HHL491	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1798	HHL492	2014	Holden Cruze S/W	410-4222	Greenlane	
1801	HHL493	2014	Holden Cruze S/W	445-4643	Morningside	
1802	HHL494	2014	Holden Cruze S/W	445-4639	Greenlane	
1803	HHL495	2014	Holden Cruze S/W	420-4233	Greenlane	
1804	HHL496	2014	Holden Cruze S/W	445-4639	Greenlane	
1805	HHL497	2014	Holden Cruze S/W	445-4633	Taylor Centre	
1806	HJH715	2014	Hyundai Accent	410-4227	Greenlane	
1810	HJH716	2014	Hyundai Accent	445-4633	Taylor Centre	
1808	HJH717	2014	Hyundai i20	410-4227	Greenlane	
1811	HJH718	2014	Hyundai Accent	410-3044	Greenlane	
1809	HJH719	2014	Hyundai Accent	445-4505	Greenlane	
1807	HJH720	2014	Hyundai Accent	410-4227	Greenlane	

1820	HLM80	2014	Mercedes Benz Sprinter	420-4246	Greenlane	
1821	HNF128	2014	Mercedes Benz Sprinter	420-4246	Greenlane	
1822	HPA212	2014	Hyundai Accent	445-4635	Greenlane	
1830	HPA213	2014	Hyundai Accent	445-4626	Panmure	
1828	HPA247	2014	Hyundai I20	445-4643	Morningside	
Fleet Number	Registration Number	Registration Year	Make and model	Cost Centre	Location	Decommissioned
1829	HPA248	2014	Hyundai I20	445-4643	Morningside	
1826	HPA249	2014	Hyundai I20	410-4227	Greenlane	
1827	HPA250	2014	Hyundai I20	410-4227	Greenlane	
1823	HPA251	2014	Hyundai I20	445-4635	Greenlane	
1824	HPA252	2014	Hyundai I20	420-4246	Greenlane	
1825	HPA253	2014	Hyundai I20	420-4246	Greenlane	
1840	HUM831	2015	Holden Cruze S/W	445-4635	Greenlane	
1839	HUM832	2015	Holden Cruze S/W	445-4633	Taylor Centre	
1835	HUM833	2015	Holden Cruze S/W	445-4627	Morningside	
1834	HUY669	2015	Toyota HiAce ZL	430-5631	Auckland Hospital	
1842	HWA470	2015	Hyundai I20	445-4635	Greenlane	
1837	HWA471	2015	Hyundai I20	445-4627	Morningside	
1841	HWA473	2015	Hyundai I20	445-4635	Greenlane	
1838	HWA474	2015	Hyundai I20	445-4627	Morningside	
1843	HWA475	2015	Hyundai Accent	445-4635	Greenlane	
1836	HWA476	2015	Hyundai Accent	445-4627	Morningside	
1833	HYP346	2015	Hyundai I20	410-4227	Greenlane	
1845	HYU519	2015	Hyundai I20	410-4223	54,Carrington Road	
1846	HYU520	2015	Hyundai I20	410-4227	Greenlane	
1851	HYU521	2015	Hyundai I20	420-4246	Greenlane	
1852	HYU522	2015	Hyundai I20	420-4246	Greenlane	
1844	HYU523	2015	Hyundai I20	410-3636	Greenlane	
1854	HYU579	2015	Hyundai I20	420-4246	Greenlane	
1847	HYZ774	2015	Holden Barina 1.6	410-4227	Greenlane	16/10/2017
1848	HYZ775	2015	Holden Barina 1.6	410-4227	Greenlane	
1849	HYZ776	2015	Holden Barina 1.6	420-4237	Greenlane	
1850	HYZ778	2015	Holden Barina 1.6	420-4246	Greenlane	
1853	HYZ779	2015	Holden Cruze S/W	420-4246	Greenlane	
1858	JAA941	2015	Hyundai Accent	445-4625	Greenlane	
1859	JAA942	2015	Hyundai I20	445-4626	Panmure	
1860	JAA943	2015	Hyundai I20	445-4626	Panmure	
1857	JAA944	2015	Hyundai I20	445-4625	Greenlane	
1861	JAA945	2015	Hyundai Accent	445-4639	Greenlane	
1855	JAL365	2015	Holden Cruze S/W	430-5631	Auckland Hospital	
1856	JAL367	2015	Holden Cruze S/W	445-2029	Auckland Hospital	
1863	JFT376	2015	Holden Barina 1.6	445-4635	Greenlane	

1864	JFT378	2015	Holden Barina 1.6	445-4635	Greenlane	
1867	JFT379	2015	Holden Barina 1.6	445-4627	Morningside	
1868	JFT380	2015	Holden Cruze S/W	445-2028	Grafton	
1907	JGH158	2015	Hyundai Accent	445-4634	Manawanui	
1865	JGM254	2015	Hyundai I20	445-4626	Panmure	
1866	JGM255	2015	Hyundai I20	445-4627	Morningside	
Fleet Number	Registration Number	Registration Year	Make and model	Cost Centre	Location	Decommissioned
1800	JGR998	2014	Holden Cruze S/W	445-4643	Morningside	
1871	JKB537	2015	Hyundai I20	445-4505	Greenlane	
1872	JKB538	2015	Hyundai I20	445-4505	Greenlane	
1902	KCC39	2016	Holden Barina 1.6	445-4637	Greenlane	
1767	KDC795	2013	Hyundai Imax 8 seat	445-4634	Manawanui	
1906	KGL165	2017	Holden Barina 1.6	445-4627	Morningside	
1920	KKC39	2016	Holden Barina 1.6	445-4637	Greenlane	03/04/2017
6800	TB7719	1994	LEYLAND LDV400	23133C	Rehab Plus	

Vehicles
2015/2016

Fleet Number	Registration Number	Registration Year	Make and model	RC Number	Location	Decommissioned
1490	ALQ457	2002	Toyota Hiace ZR	410-4223	54,Carrington Rd.	
1489	AME361	2002	Toyota Hiace ZR	430-5631	Greenlane Hospital	
1484	ANW956	2002	Toyota Hiace ZL	445-2030	27,Sutherland Rd.	
1485	ANW960	2002	Toyota Hiace ZL	445-2030	27,Sutherland Rd.	
1080	BAL235	2002	Toyota Hiace ZX	410-4223	54,Carrington Rd.	
1165	BJM699	2003	Toyota Hiace ZL	445-4639	Greenlane	03/05/2016
1068	BJU595	2003	Toyota Hiace	445-2031	SSH	
1052	BTJ351	2004	Toyota Hiace ZL	445-4636	Buchanan Clinic	
1390	DBN306	2005	Hyundai Getz	445-4626	Panmure	20/08/2015
1392	DBN309	2005	Hyundai Getz	445-4634	Greenlane	04/08/2015
1334	DNK418	2006	Hyundai Getz	445-4635	Greenlane	12/08/2015
1331	DNK421	2006	Hyundai Getz	445-4627	Morningside	20/08/2015
1251	DNK422	2006	Hyundai Getz	445-4627	Morningside	12/08/2015
1355	DNK423	2006	Hyundai Getz	445-4626	Panmure	
1353	DNK424	2006	Hyundai Getz	445-4626	Panmure	
1252	DNK425	2006	Hyundai Getz	445-4633	Taylor Centre	09/06/2016
1425	DNU448	2006	Hyundai Getz	415-3646	Greenlane	
1501	DWW348	2007	Mitsubishi L300	445-4637	218,Gt.South Road	
1502	DZS404	2007	Hyundai Getz	410-4223	54,Carrington Rd.	
1504	EAN617	2007	Nissan Tiida	445-4639	Greenlane	13/05/2016
1503	EAQ333	2007	Mitsubishi Fuso	430-6001	Auckland Hospital	
1505	ECM799	2007	Hyundai Getz	445-4626	Panmure	
1506	ECP855	2007	Hyundai Getz	410-4227	Greenlane	09/06/2016
1507	ECT993	2007	Hyundai Getz	445-4505	Greenlane	
1508	FCU950	2007	Holden Viva S/W	445-2028	Auckland Hospital	05/08/2015
1511	EDQ846	2007	Hyundai Getz	410-4227	Greenlane	05/04/2016
1756	EDR67	2007	Hyundai Getz	410-4227	Greenlane	10/06/2016
1518	EDR68	2007	Hyundai Getz	445-4639	Greenlane	13/05/2016
1515	EDR70	2007	Hyundai Getz	445-4636	27,Sutherland Rd.	
1514	EDR75	2007	Hyundai Getz	445-4634	Manawanui	
1513	EDR76	2007	Hyundai Getz	445-4634	Manawanui	
1512	EDR77	2007	Hyundai Getz	445-4634	Manawanui	
1510	EDR79	2007	Hyundai Getz	445-4627	Morningside	
1509	EDR81	2007	Hyundai Getz	445-2028	Auckland Hospital	
1520	EDT377	2007	Nissan Wingroad S/W	450-6009	Auckland Hospital	
1333	EFG468	2006	Hyundai Getz	445-4633	Waiheke Isl	
1522	EFK552	2007	Hyundai Getz	445-4635	Greenlane	
1521	EFK553	2007	Hyundai Getz	445-4635	Greenlane	
1523	EJA39	2008	Hyundai Getz	455-8516	Greenlane	07/04/2016
1525	EJD640	2008	Nissan Wingroad S/W	455-8516	Greenlane	13/05/2016

1527	EJR580	2008	Hyundai Getz	455-8514	Greenlane	
1526	EJR581	2008	Hyundai Getz	455-8514	Greenlane	
1551	EKC537	2008	Holden Viva S/W	430-6001	Auckland Hospital	15/11/2017
1552	EKC538	2008	Holden Viva S/W	430-6001	Auckland Hospital	
1554	EKC539	2008	Holden Viva S/W	430-6001	Auckland Hospital	
1553	EKC540	2008	Holden Viva S/W	430-6001	Auckland Hospital	
1539	EKC641	2008	Nissan Wingroad S/W	455-8516	Greenlane	13/05/2016
1540	EKC642	2008	Nissan Wingroad S/W	410-4223	54,Carrington Rd	
1538	EKC672	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1541	EKC679	2008	Nissan Wingroad S/W	420-4246	Greenlane	
1542	EKC680	2008	Nissan Wingroad S/W	430-5343	Auckland Hospital	
1533	EKG729	2008	Hyundai Getz	445-2030	27,Sutherland Rd.	
1534	EKG730	2008	Hyundai Getz	445-2030	27,Sutherland Rd.	
1531	EKG732	2008	Hyundai Getz	445-4636	Morningside	
1543	EKG733	2008	Hyundai Getz	455-8514	Greenlane	
1530	EKG734	2008	Hyundai Getz	455-8514	Greenlane	06/12/2016
1529	EKG735	2008	Hyundai Getz	455-8514	Greenlane	
1537	EKG736	2008	Hyundai Getz	455-8514	Greenlane	06/12/2016
1536	EKG737	2008	Hyundai Getz	455-8516	Greenlane	07/04/2016
1532	EKG739	2008	Hyundai Getz	455-8514	Greenlane	
1544	ELH285	2008	Hyundai Getz	455-8514	Greenlane	10/06/2016
1545	ELH286	2008	Hyundai Getz	445-4633	Taylor Centre	
1546	ELH287	2008	Hyundai Getz	455-8514	Greenlane	10/06/2016
1547	ELH288	2008	Hyundai Getz	410-4223	Pt.Chevalier	
1549	ELH289	2008	Hyundai Getz	430-6001	Auckland Hospital	07/04/2016
1548	ELH295	2008	Hyundai Getz	410-3636	Greenlane	
1550	ELK655	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1555	ELT798	2008	Hyundai Getz	445-4634	Manawanui	
1556	EMD901	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1557	EMD902	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1558	EMD903	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1559	EMD904	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1560	EMD905	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1561	EMD906	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1562	EMD907	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1563	EMD908	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1564	EMD909	2008	Nissan Wingroad S/W	410-4227	Greenlane	

1565	EMD910	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1567	EMY209	2008	Hyundai Getz	415-2020	Auckland Hospital	
1568	EMY210	2008	Hyundai Getz	455-8516	Greenlane	05/04/2016
1569	EMY211	2008	Hyundai Getz	445-4643	Morningside	27/03/2017
1566	EMY213	2008	Hyundai Getz	415-3646	Greenlane	
1571	EPL469	2008	Ford Transit	420-4246	Greenlane	
1575	ERK447	2008	Hyundai Getz	420-4246	Greenlane	
1574	ERK448	2008	Hyundai Getz	420-4246	Greenlane	
1573	ERK449	2008	Hyundai Getz	420-4246	Greenlane	
1572	ERK450	2008	Hyundai Getz	420-4246	Greenlane	
1576	ERP983	2008	Hyundai Getz	420-4246	Greenlane	
1577	ERR110	2008	Nissan Wingroad S/W	420-4246	Greenlane	
1354	ESC686	2006	Hyundai Getz	445-4635	Greenlane	12/08/2015
1582	ETS863	2009	Nissan Wingroad S/W	430-5343	Auckland Hospital	
1580	ETS865	2009	Nissan Wingroad S/W	420-4246	Greenlane	
1579	ETS866	2009	Nissan Wingroad S/W	420-4246	Greenlane	
1578	ETS867	2009	Nissan Wingroad S/W	420-4246	Greenlane	14/10/2015
1524	ETW467	2008	Hyundai Getz	445-4637	Greenlane	
1764	EUJ792	2008	Hyundai Getz	420-4241	Greenlane	
1758	EUJ794	2008	Hyundai Getz	445-4633	Taylor Centre	
1759	EUW326	2009	Hyundai Getz	445-4633	Taylor Centre	
1763	EWL470	2009	Hyundai Getz	420-4246	Greenlane	
1766	EWZ911	2009	Hyundai Getz	420-4241	Greenlane	11/08/2017
1762	EWZ916	2009	Hyundai Getz	420-4246	Greenlane	
1589	EYK550	2009	Hyundai Getz	455-8514	Greenlane	
1586	EYK551	2009	Hyundai Getz	445-4635	Manawanui	
1591	EYK552	2009	Hyundai Getz	455-8516	Greenlane	07/04/2016
1606	EYK552	2009	Hyundai Getz	455-8516	Greenlane	05/04/2016
1592	EYK553	2009	Hyundai Getz	455-8514	Greenlane	
1595	EYK554	2009	Hyundai Getz	455-8514	Greenlane	
1584	EYK555	2009	Hyundai Getz	455-8514	Greenlane	
1593	EYK557	2009	Hyundai Getz	455-8514	Greenlane	05/09/2016
1590	EYK558	2009	Hyundai Getz	445-4633	Taylor Centre	
1761	EYK584	2009	Hyundai Getz	430-6001	Greenlane Hospital	
1585	EYK598	2009	Hyundai Getz	420-4246	Greenlane	
1588	EYK599	2009	Hyundai Getz	445-4633	Taylor Centre	
1587	EYK600	2009	Hyundai Getz	445-4633	Taylor Centre	
1596	EYU95	2009	Hyundai Getz	455-8514	Greenlane	06/12/2016
1597	EYU96	2009	Hyundai Getz	420-4246	Greenlane	
1599	EYU98	2009	Hyundai Getz	455-8516	Greenlane	05/04/2016
1600	EYU99	2009	Hyundai Getz	420-4246	Greenlane	
1610	EZD602	2009	Nissan Wingroad S/W	410-4227	Greenlane	

1601	EZD903	2009	Hyundai Getz	455-8514	Greenlane	06/12/2016
1602	EZJ559	2009	Hyundai Getz	455-8514	Greenlane	
1603	EZJ560	2009	Hyundai Getz	410-4223	54,Carrington Rd.	
1604	EZJ561	2009	Hyundai Getz	455-8516	Greenlane	05/04/2016
1605	EZJ562	2009	Hyundai Getz	455-8514	Greenlane	
1607	EZJ564	2009	Hyundai Getz	455-8514	Greenlane	06/12/2016
1608	EZJ565	2009	Hyundai Getz	455-8516	Greenlane	07/04/2016
1609	EZJ566	2009	Hyundai Getz	420-4246	Greenlane	
1611	EZU776	2009	Hyundai Getz	445-4505	Greenlane	
1612	EZU777	2009	Hyundai Getz	410-4227	Greenlane	
1613	EZU778	2009	Hyundai Getz	410-4227	Greenlane	
1614	EZU779	2009	Hyundai Getz	410-4227	Greenlane	
1615	FAC249	2009	Hyundai Getz	445-4626	Panmure	
1616	FAC250	2009	Hyundai Getz	410-4222	Greenlane	
1617	FAC251	2009	Hyundai Getz	445-4627	Morningside	
1618	FAC252	2009	Hyundai Getz	445-4637	Greenlane	
1619	FAC253	2009	Hyundai Getz	445-4637	Greenlane	
1620	FAC254	2009	Hyundai Getz	445-4637	Greenlane	
1760	FAC255	2009	Hyundai Getz	430-6001	Greenlane	
1621	FAL581	2009	Hyundai Getz	445-4628	Greenlane	
1622	FAU41	2009	Hyundai Getz	410-4227	Greenlane	
1623	FAU61	2009	Hyundai Getz	410-4227	Greenlane	
1624	FAU62	2009	Hyundai Getz	410-4227	Greenlane	
1625	FAU63	2009	Hyundai Getz	410-4227	Greenlane	
1626	FAU64	2009	Hyundai Getz	410-4227	Greenlane	
1627	FAU65	2009	Hyundai Getz	410-4227	Greenlane	
1628	FAU66	2009	Hyundai Getz	410-4227	Greenlane	
1630	FAU68	2009	Hyundai Getz	410-4227	Greenlane	
1631	FAU69	2009	Hyundai Getz	410-4227	Greenlane	
1632	FAU70	2009	Hyundai Getz	410-4227	Greenlane	
1633	FAU71	2009	Hyundai Getz	410-4227	Greenlane	
1634	FBU225	2009	Hyundai i30	420-4246	Greenlane	
1635	FBU226	2009	Hyundai Getz	410-4227	Greenlane	
1636	FBU227	2009	Hyundai Getz	410-4227	Greenlane	
1637	FBU228	2009	Hyundai Getz	410-4227	Greenlane	
1638	FBU229	2009	Hyundai Getz	410-4227	Greenlane	
1639	FBU233	2009	Hyundai Tuscon AWD	455-8514	Greenlane	
1765	FDH159	2009	Hyundai Getz	420-4241	Greenlane	
1640	FEL649	2010	Mercedes Benz Sprinter	450-8915	Greenlane	
1642	FFC632	2010	Mercedes Benz Sprinter	450-8915	Sylvia Park	
1641	FFL670	2010	Hyundai i30 S/W	430-5631	Auckland Hospital	
1648	FKS992	2010	Hyundai Getz	445-4637	Greenlane	
1647	FKS993	2010	Hyundai Getz	420-4237	Auckland Hospital	
1646	FKS994	2010	Hyundai Getz	445-4635	Greenlane	

1645	FKS995	2010	Hyundai Getz	415-3646	Greenlane	
1644	FKS996	2010	Hyundai Getz	415-3646	Auckland Hospital	
1649	FML964	2010	Mercedes Benz Sprinter	450-8915	Avondale	
1650	FQB564	2010	Hyundai Getz	410-4227	Greenlane	
1651	FQB565	2010	Hyundai Getz	410-4227	Greenlane	29/07/2015
1652	FQB566	2010	Hyundai Getz	410-4227	Greenlane	
1653	FQB567	2010	Hyundai Getz	455-8514	Greenlane	
1654	FQB568	2010	Hyundai Getz	410-4222	Greenlane	
1655	FQB569	2010	Hyundai Getz	445-4626	Panmure	
1656	FQB570	2010	Hyundai Getz	445-4627	Morningside	
1799	FQB571	2010	Hyundai Getz	445-4625	Greenlane	
1658	FQB572	2010	Hyundai Getz	445-4643	Morningside	
1659	FQB573	2010	Hyundai Getz	445-4633	Taylor Centre	
1660	FQB574	2010	Hyundai Getz	445-4635	Greenlane	
1661	FQB575	2010	Hyundai Getz	445-4635	Greenlane	
1535	FRC403	2008	Hyundai Getz	445-2030	27,Sutherland Rd.	
1662	FRP511	2010	Hyundai Getz	445-4633	Waiheke Isl	
1663	FRP512	2010	Hyundai Getz	445-4637	Greenlane	05/04/2016
1664	FRP513	2010	Hyundai Getz	420-4246	Greenlane	
1665	FRP514	2010	Hyundai Getz	420-4246	Greenlane	
1666	FRP515	2010	Hyundai Getz	420-4246	Greenlane	
1667	FRP516	2010	Hyundai Getz	420-4246	Greenlane	
1668	FRP517	2010	Hyundai Getz	420-4246	Greenlane	
1669	FRP518	2010	Hyundai Getz	420-4246	Greenlane	
1670	FRP519	2010	Hyundai Getz	445-4625	Greenlane	
1671	FRP520	2010	Hyundai Getz	445-4625	Greenlane	
1673	FRP521	2010	Hyundai Getz	445-4626	Panmure	
1672	FRP522	2010	Hyundai Getz	445-4625	Greenlane	
1685	FSJ981	2011	Hyundai Getz	445-4633	Taylor Centre	
1684	FSJ982	2011	Hyundai Getz	445-4633	Taylor Centre	
1683	FSJ983	2011	Hyundai Getz	445-4627	Morningside	
1682	FSJ984	2011	Hyundai Getz	445-4627	Morningside	
1681	FSJ985	2011	Hyundai Getz	420-4246	Greenlane	
1680	FSJ986	2011	Hyundai Getz	420-4246	Greenlane	
1679	FSJ987	2011	Hyundai Getz	420-4246	Greenlane	
1678	FSJ988	2011	Hyundai Getz	420-4246	Greenlane	
1677	FSJ989	2011	Hyundai Getz	420-4246	Greenlane	
1676	FSJ990	2011	Hyundai Getz	420-4246	Greenlane	
1675	FSJ991	2011	Hyundai Getz	410-4227	Greenlane	
1674	FSK20	2011	Hyundai Getz	410-4227	Greenlane	
1699	FTD100	2011	Hyundai Getz	445-4626	Panmure	
1686	FTD104	2011	Hyundai Getz	410-4227	Greenlane	
1687	FTD105	2011	Hyundai Getz	410-4227	Greenlane	22/07/2015
1688	FTD89	2011	Hyundai Getz	410-4227	Greenlane	
1689	FTD90	2011	Hyundai Getz	410-4227	Greenlane	

1690	FTD91	2011	Hyundai Getz	410-4227	Greenlane	
1691	FTD92	2011	Hyundai Getz	410-4223	Pt.Chevalier	
1692	FTD93	2011	Hyundai Getz	410-4227	Greenlane	
1693	FTD94	2011	Hyundai Getz	420-4246	Greenlane	
1694	FTD95	2011	Hyundai Getz	420-4246	Greenlane	
1695	FTD96	2011	Hyundai Getz	420-4246	Greenlane	
1696	FTD97	2011	Hyundai Getz	420-4246	Greenlane	
1697	FTD98	2011	Hyundai Getz	445-4626	Panmure	
1698	FTD99	2011	Hyundai Getz	445-4626	Panmure	
1702	FUL165	2011	Hyundai i30 S/W	420-4246	Greenlane	
1700	FUL166	2011	Hyundai i30 S/W	410-4227	Greenlane	
1701	FUL167	2011	Hyundai i30 S/W	410-4227	Greenlane	
1715	FWM180	2011	Mercedes Benz Sprinter	450-8915	Sylvia Park	
1703	FYC70	2011	Hyundai Getz	445-4626	Panmure	
1704	FYC71	2011	Hyundai Getz	445-4627	Morningside	
1705	FYC72	2011	Hyundai Getz	445-4627	Morningside	
1706	FYC73	2011	Hyundai Getz	445-4627	Morningside	
1707	FYC74	2011	Hyundai Getz	445-4627	Morningside	
1709	FYC75	2011	Hyundai Getz	445-4633	Taylor Centre	
1708	FYC76	2011	Hyundai Getz	445-4627	Morningside	19/10/2016
1710	FYC77	2011	Hyundai Getz	445-4635	Greenlane	
1711	FYC78	2011	Hyundai Getz	445-4635	Greenlane	
1712	FYC79	2011	Hyundai Getz	415-3646	Greenlane	
1713	FYC80	2011	Hyundai Getz	415-3646	Greenlane	
1714	FYC81	2011	Hyundai Getz	430-6001	Greenlane	
1716	GCH831	2011	Hyundai i20	445-4625	Greenlane	
1717	GCH832	2011	Hyundai i20	445-4625	Greenlane	
1718	GCH833	2011	Hyundai i20	410-4227	Greenlane	
1719	GCH834	2011	Hyundai i20	410-4227	Greenlane	
1720	GCH835	2011	Hyundai i20	410-4227	Greenlane	
1721	GCH836	2011	Hyundai i20	410-4227	Greenlane	
1722	GCH842	2011	Hyundai i20	410-4227	Greenlane	
1723	GCH843	2011	Hyundai i20	410-4227	Greenlane	
1724	GCH844	2011	Hyundai i20	410-4227	Greenlane	
1725	GCH845	2011	Hyundai i20	410-4227	Greenlane	
1734	GFP401	2012	Hyundai i20	410-4227	Greenlane	
1735	GFP402	2012	Hyundai i20	420-4246	Greenlane	
1732	GFP403	2012	Hyundai i20	410-4227	Greenlane	
1731	GFP404	2012	Hyundai i20	410-4227	Greenlane	
1728	GFP405	2012	Hyundai i20	410-4227	Greenlane	
1730	GFP406	2012	Hyundai i20	410-4227	Greenlane	
1736	GFP407	2012	Hyundai i20	420-4246	Greenlane	
1729	GFP408	2012	Hyundai i20	410-4227	Greenlane	
1733	GFP409	2012	Hyundai i20	410-4227	Greenlane	
1727	GFP410	2012	Hyundai i20	410-4227	Greenlane	
1744	GGZ920	2012	Hyundai i20	410-4227	Greenlane	

1745	GHT500	2012	Mercedes Benz Sprinter	450-8915	Greenlane	
1746	GJN182	2012	Mercedes Benz Sprinter	450-8915	Sandringham	
1747	GPF169	2012	Toyota Hilux 3.0.TD	455-8514	Greenlane	
1768	GUZ903	2013	Hyundai i20	420-4241	Greenlane	
1769	GUZ904	2013	Hyundai i20	445-4625	Greenlane	
1770	GUZ905	2013	Hyundai i20	445-4625	Greenlane	
1771	GUZ906	2013	Hyundai i20	445-4625	Greenlane	
1772	GUZ907	2013	Hyundai i20	420-4246	Greenlane	
1773	GUZ908	2013	Hyundai i20	415-2020	Auckland Hospital	
1774	GUZ909	2013	Hyundai i20	445-4633	Taylor Centre	
1775	GUZ910	2013	Hyundai i20	445-4633	Taylor Centre	
1776	GUZ911	2013	Hyundai i20	420-3111	Grafton	
1778	GUZ913	2013	Hyundai i20	415-3646	Greenlane	
1779	GUZ914	2013	Hyundai i20	415-3646	Greenlane	
1780	GUZ915	2013	Hyundai i20	410-4227	Greenlane	
1781	GUZ916	2013	Hyundai i20	410-4227	Greenlane	
1782	GUZ917	2013	Hyundai i20	410-4227	Greenlane	
1784	GWN703	2013	Toyota Corolla S/W	445-4637	Greenlane	
1783	GWT179	2013	Hyundai i20	445-4637	Greenlane	
1786	HCY632	2013	Hyundai Accent	445-4627	Morningside	
1785	HCY633	2013	Hyundai Accent	410-4226	Auckland Hospital	
1795	HFG156	2014	Hyundai i20	410-4227	Greenlane	
1788	HFP233	2014	Holden Cruze S/W	420-4246	Greenlane	
1787	HFP234	2014	Holden Cruze S/W	420-4246	Greenlane	
1789	HFP235	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1790	HFP236	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1791	HFP237	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1792	HFP238	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1793	HFP239	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1794	HFP240	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1796	HHL489	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1797	HHL491	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1798	HHL492	2014	Holden Cruze S/W	410-4222	Greenlane	
1801	HHL493	2014	Holden Cruze S/W	445-4643	Morningside	
1802	HHL494	2014	Holden Cruze S/W	445-4639	Greenlane	
1803	HHL495	2014	Holden Cruze S/W	420-4233	Greenlane	
1804	HHL496	2014	Holden Cruze S/W	445-4639	Greenlane	
1805	HHL497	2014	Holden Cruze S/W	445-4633	Taylor Centre	
1806	HJH715	2014	Hyundai Accent	410-4227	Greenlane	
1810	HJH716	2014	Hyundai Accent	445-4633	Taylor Centre	
1808	HJH717	2014	Hyundai i20	410-4227	Greenlane	
1811	HJH718	2014	Hyundai Accent	410-3044	Greenlane	
1809	HJH719	2014	Hyundai Accent	445-4505	Greenlane	
1807	HJH720	2014	Hyundai Accent	410-4227	Greenlane	

1820	HLM80	2014	Mercedes Benz Sprinter	420-4246	Greenlane	
1821	HNF128	2014	Mercedes Benz Sprinter	420-4246	Greenlane	
1822	HPA212	2014	Hyundai Accent	445-4635	Greenlane	
1830	HPA213	2014	Hyundai Accent	445-4626	Panmure	
1828	HPA247	2014	Hyundai i20	445-4643	Morningside	
1829	HPA248	2014	Hyundai i20	445-4643	Morningside	
1826	HPA249	2014	Hyundai i20	410-4227	Greenlane	
1827	HPA250	2014	Hyundai i20	410-4227	Greenlane	
1823	HPA251	2014	Hyundai i20	445-4635	Greenlane	
1824	HPA252	2014	Hyundai i20	420-4246	Greenlane	
1825	HPA253	2014	Hyundai i20	420-4246	Greenlane	
1840	HUM831	2015	Holden Cruze S/W	445-4635	Greenlane	
1839	HUM832	2015	Holden Cruze S/W	445-4633	Taylor Centre	
1835	HUM833	2015	Holden Cruze S/W	445-4627	Morningside	
1834	HUY669	2015	Toyota HiAce ZL	430-5631	Auckland Hospital	
1842	HWA470	2015	Hyundai i20	445-4635	Greenlane	
1837	HWA471	2015	Hyundai i20	445-4627	Morningside	
1841	HWA473	2015	Hyundai i20	445-4635	Greenlane	
1838	HWA474	2015	Hyundai i20	445-4627	Morningside	
1843	HWA475	2015	Hyundai Accent	445-4635	Greenlane	
1836	HWA476	2015	Hyundai Accent	445-4627	Morningside	
1833	HYP346	2015	Hyundai i20	410-4227	Greenlane	
1845	HYU519	2015	Hyundai i20	410-4223	54,Carrington Road	
1846	HYU520	2015	Hyundai i20	410-4227	Greenlane	
1851	HYU521	2015	Hyundai i20	420-4246	Greenlane	
1852	HYU522	2015	Hyundai i20	420-4246	Greenlane	
1844	HYU523	2015	Hyundai i20	410-3636	Greenlane	
1854	HYU579	2015	Hyundai i20	420-4246	Greenlane	
1847	HYZ774	2015	Holden Barina 1.6	410-4227	Greenlane	16/10/2017
1848	HYZ775	2015	Holden Barina 1.6	410-4227	Greenlane	
1849	HYZ776	2015	Holden Barina 1.6	420-4237	Greenlane	
1850	HYZ778	2015	Holden Barina 1.6	420-4246	Greenlane	
1853	HYZ779	2015	Holden Cruze S/W	420-4246	Greenlane	
1858	JAA941	2015	Hyundai Accent	445-4625	Greenlane	
1859	JAA942	2015	Hyundai i20	445-4626	Panmure	
1860	JAA943	2015	Hyundai i20	445-4626	Panmure	
1857	JAA944	2015	Hyundai i20	445-4625	Greenlane	
1861	JAA945	2015	Hyundai Accent	445-4639	Greenlane	
1855	JAL365	2015	Holden Cruze S/W	430-5631	Auckland Hospital	
1856	JAL367	2015	Holden Cruze S/W	445-2029	Auckland Hospital	
1863	JFT376	2015	Holden Barina 1.6	445-4635	Greenlane	
1864	JFT378	2015	Holden Barina 1.6	445-4635	Greenlane	
1867	JFT379	2015	Holden Barina 1.6	445-4627	Morningside	
1868	JFT380	2015	Holden Cruze S/W	445-2028	Grafton	

1907	JGH158	2015	Hyundai Accent	445-4634	Manawanui	
1865	JGM254	2015	Hyundai I20	445-4626	Panmure	
1866	JGM255	2015	Hyundai I20	445-4627	Morningside	
1800	JGR998	2014	Holden Cruze S/W	445-4643	Morningside	
1871	JKB537	2015	Hyundai I20	445-4505	Greenlane	
1872	JKB538	2015	Hyundai I20	445-4505	Greenlane	
1873	JNZ440	2016	Holden Cruze S/W	420-4246	Greenlane3	
1875	JRG265	2016	Hyundai I20	420-4246	Greenlane	
1876	JRG266	2016	Hyundai I20	420-4246	Greenlane	
1874	JRG267	2016	Hyundai I20	410-4227	Greenlane	
1883	JRG268	2016	Hyundai I20	455-8514	Greenlane	
1889	JRG269	2016	Hyundai I20	455-8514	Greenlane	
1885	JRG270	2016	Hyundai I20	455-8514	Greenlane	
1888	JRG271	2016	Hyundai I20	455-8514	Greenlane	
1879	JRG272	2016	Hyundai I20	430-6001	Auckland Hospital	
1877	JRG273	2016	Hyundai I20	420-4246	Greenlane	
1878	JRG274	2016	Hyundai I20	420-4246	Greenlane	
1890	JRG275	2016	Hyundai I20	455-8514	Greenlane	
1891	JRG276	2016	Hyundai I20	455-8514	Greenlane	
1887	JRG277	2016	Hyundai I20	455-8514	Greenlane	
1886	JRG278	2016	Hyundai I20	455-8514	Greenlane	
1884	JTF795	2016	Holden Cruze S/W	455-8514	Greenlane	
1882	JTF796	2016	Holden Cruze S/W	455-8514	Greenlane	
1880	JTF797	2016	Holden Cruze S/W	445-4639	Greenlane	
1881	JTF798	2016	Holden Cruze S/W	445-4639	Greenlane	
1892	JTW904	2016	Hyundai I20	455-8514	Greenlane	
1896	JTW905	2016	Hyundai I20	445-4633	Taylor Centre	
1893	JTW906	2016	Hyundai I20	455-8514	Greenlane	
1894	JTW907	2016	Hyundai I20	410-4227	Greenlane	
1895	JTW908	2016	Hyundai I20	410-4227	Greenlane	
1767	KDC795	2013	Hyundai Imax 8 seat	445-4634	Manawanui	
6800	TB7719	1994	LEYLAND LDV400	23133C	Rehab Plus	

Vehicles**2014/201****5**

Fleet Number	Registration Number	Registration Year	Make and model	RC Number	Location	Decommissioned
9337	AAE489	2001	Ford Transit	420-4246	Greenlane	24/09/2014
1486	ALC239	2001	Toyota Hiace	450-8243	Greenlane	16/04/2015
1490	ALQ457	2002	Toyota Hiace ZR	410-4223	54,Carrington Rd.	
1489	AME361	2002	Toyota Hiace ZR	430-5631	Greenlane Hospital	
1488	AME362	2002	Toyota Hiace	430-5631	Auckland Hospital	22/10/2014
1484	ANW956	2002	Toyota Hiace ZL	445-2030	27,Sutherland Rd.	

1485	ANW960	2002	Toyota Hiace ZL	445-2030	27,Sutherland Rd.	
1080	BAL235	2002	Toyota Hiace ZX	410-4223	54,Carrington Rd.	
1165	BJM699	2003	Toyota Hiace ZL	445-4639	Greenlane	03/05/2016
1068	BJU595	2003	Toyota Hiace	445-2031	SSH	
1052	BTJ351	2004	Toyota Hiace ZL	445-4636	Buchanan Clinic	
1056	BTJ361	2004	Daihatsu Sirion	450-8553	Greenlane	20/02/2015
1480	BWU536	2004	Toyota Corolla S/W	445-4627	Morningside	14/01/2015
1479	BWU537	2004	Toyota Corolla S/W	445-4627	Morningside	18/02/2015
1103	CBH901	2004	Toyota Corolla S/W	445-4635	Greenlane	09/03/2015
1107	CBH907	2004	Toyota Corolla S/W	445-4633	Taylor Centre	18/02/2015
1451	CLS716	2005	Toyota Corolla S/W	445-2029	Auckland Hospital	08/04/2015
1075	CQH303	2005	Hyundai Getz	420-4246	Greenlane	09/03/2015
1450	CRK146	2005	Toyota Corolla	445-4625	Greenlane	09/04/2015
1814	CRS703	2007	Hyundai Getz	450-8243	Takapuna	16/04/2015
1276	CSL971	2005	Hyundai Getz	445-4626	Panmure	08/04/2015
1753	CSQ292	2005	Hyundai Getz	420-4246	Greenlane	10/03/2015
1368	CYN875	2005	Hyundai Getz	410-4223	54,Carrington Rd.	09/03/2015
1815	CZL14	2005	Mitsubishi Lancer S/W	450-8243	Middlemore	16/04/2015
1394	DAM367	2005	Toyota Corolla S/W	430-5631	Auckland Hospital	07/04/2015
1385	DBN301	2005	Hyundai Getz	410-4220	Greenlane	09/03/2015
1386	DBN302	2005	Hyundai Getz	420-4246	Greenlane	26/08/2014
1387	DBN303	2005	Hyundai Getz	420-4237	Auckland Hospital	10/03/2015
1388	DBN304	2005	Hyundai Getz	420-4246	Greenlane	09/03/2015
1389	DBN305	2005	Hyundai Getz	410-4227	Greenlane	09/03/2015
1390	DBN306	2005	Hyundai Getz	445-4626	Panmure	20/08/2015
1391	DBN307	2005	Hyundai Getz	445-4626	Panmure	07/04/2015
1392	DBN309	2005	Hyundai Getz	445-4634	Greenlane	04/08/2015
1393	DBN310	2005	Hyundai Getz	445-4635	Greenlane	14/01/2015
1752	DBN313	2005	Hyundai Getz	420-4246	Greenlane	26/08/2014
1152	DBN315	2005	Hyundai Getz	445-4627	Morningside	14/01/2015
1444	DBN316	2005	Hyundai Getz	445-4643	Morningside	26/08/2014
1419	DBN318	2005	Hyundai Getz	445-4627	Morningside	14/01/2015
1420	DBN320	2005	Hyundai Getz	410-4227	Greenlane	26/08/2014
1755	DBN321	2005	Hyundai Getz	410-4227	Greenlane	10/03/2015
1423	DBW382	2005	Hyundai Getz	445-4625	Greenlane	08/04/2015
1441	DCK203	2005	Nissan Pulsar S/W	420-4246	Greenlane	10/03/2015
1334	DNK418	2006	Hyundai Getz	445-4635	Greenlane	12/08/2015
1332	DNK420	2006	Hyundai Getz	445-4635	Greenlane	25/08/2014
1331	DNK421	2006	Hyundai Getz	445-4627	Morningside	20/08/2015
1251	DNK422	2006	Hyundai Getz	445-4627	Morningside	12/08/2015
1355	DNK423	2006	Hyundai Getz	445-4626	Panmure	
1353	DNK424	2006	Hyundai Getz	445-4626	Panmure	
1252	DNK425	2006	Hyundai Getz	445-4633	Taylor Centre	09/06/2016

1425	DNU448	2006	Hyundai Getz	415-3646	Greenlane	
1426	DPS864	2006	Nissan Tiida	445-4626	Panmure	26/08/2014
1427	DPS875	2006	Nissan Tiida	445-4635	Greenlane	25/08/2014
1428	DPS882	2006	Nissan Tiida	445-4639	Greenlane	07/04/2015
1754	DQP184	2006	Hyundai Getz	410-4227	Greenlane	10/03/2015
1351	DQR417	2006	Nissan Tiida	445-4635	Greenlane	22/09/2014
1817	DTP686	2007	Toyota Corolla S/W	450-8243	WDHB	29/07/2014
1818	DTP687	2007	Toyota Corolla S/W	450-8243	HAH	16/04/2015
1501	DWW348	2007	Mitsubishi L300	445-4637	218,Gt.South Road	
1816	DWW364	2007	Mitsubishi Lancer	450-8243		16/04/2015
1502	DZS404	2007	Hyundai Getz	410-4223	54,Carrington Rd.	
1504	EAN617	2007	Nissan Tiida	445-4639	Greenlane	13/05/2016
1503	EAQ333	2007	Mitsubishi Fuso	430-6001	Auckland Hospital	
1505	ECM799	2007	Hyundai Getz	445-4626	Panmure	
1506	ECP855	2007	Hyundai Getz	410-4227	Greenlane	09/06/2016
1507	ECT993	2007	Hyundai Getz	445-4505	Greenlane	
1508	ECU950	2007	Holden Viva S/W	445-2028	Auckland Hospital	05/08/2015
1511	EDQ846	2007	Hyundai Getz	410-4227	Greenlane	05/04/2016
1756	EDR67	2007	Hyundai Getz	410-4227	Greenlane	10/06/2016
1518	EDR68	2007	Hyundai Getz	445-4639	Greenlane	13/05/2016
1516	EDR69	2007	Hyundai Getz	410-4227	Greenlane	26/08/2014
1515	EDR70	2007	Hyundai Getz	445-4636	27,Sutherland Rd.	
1514	EDR75	2007	Hyundai Getz	445-4634	Manawanui	
1513	EDR76	2007	Hyundai Getz	445-4634	Manawanui	
1512	EDR77	2007	Hyundai Getz	445-4634	Manawanui	
1519	EDR78	2007	Hyundai Getz	445-4643	Morningside	26/08/2014
1510	EDR79	2007	Hyundai Getz	445-4627	Morningside	
1509	EDR81	2007	Hyundai Getz	445-2028	Auckland Hospital	
1520	EDT377	2007	Nissan Wingroad S/W	450-6009	Auckland Hospital	
1333	EFG468	2006	Hyundai Getz	445-4633	Waiheke Isl	
1522	EFK552	2007	Hyundai Getz	445-4635	Greenlane	
1521	EFK553	2007	Hyundai Getz	445-4635	Greenlane	
1523	EJA39	2008	Hyundai Getz	455-8516	Greenlane	07/04/2016
1525	EJD640	2008	Nissan Wingroad S/W	455-8516	Greenlane	13/05/2016
1527	EJR580	2008	Hyundai Getz	455-8514	Greenlane	
1526	EJR581	2008	Hyundai Getz	455-8514	Greenlane	
1551	EKC537	2008	Holden Viva S/W	430-6001	Auckland Hospital	15/11/2017
1552	EKC538	2008	Holden Viva S/W	430-6001	Auckland Hospital	
1554	EKC539	2008	Holden Viva S/W	430-6001	Auckland Hospital	
1553	EKC540	2008	Holden Viva S/W	430-6001	Auckland Hospital	
1539	EKC641	2008	Nissan Wingroad S/W	455-8516	Greenlane	13/05/2016

1540	EKC642	2008	Nissan Wingroad S/W	410-4223	54,Carrington Rd	
1538	EKC672	2008	Nissan Urvan	410-4227	Greenlane	
1541	EKC679	2008	Nissan Wingroad S/W	420-4246	Greenlane	
1542	EKC680	2008	Nissan Wingroad S/W	430-5343	Auckland Hospital	
1533	EKG729	2008	Hyundai Getz	445-2030	27,Sutherland Rd.	
1534	EKG730	2008	Hyundai Getz	445-2030	27,Sutherland Rd.	
1531	EKG732	2008	Hyundai Getz	445-4636	Morningside	
1543	EKG733	2008	Hyundai Getz	455-8514	Greenlane	
1530	EKG734	2008	Hyundai Getz	455-8514	Greenlane	06/12/2016
1529	EKG735	2008	Hyundai Getz	455-8514	Greenlane	
1537	EKG736	2008	Hyundai Getz	455-8514	Greenlane	06/12/2016
1536	EKG737	2008	Hyundai Getz	455-8516	Greenlane	07/04/2016
1532	EKG739	2008	Hyundai Getz	455-8514	Greenlane	
1544	ELH285	2008	Hyundai Getz	455-8514	Greenlane	10/06/2016
1545	ELH286	2008	Hyundai Getz	445-4633	Taylor Centre	
1546	ELH287	2008	Hyundai Getz	455-8514	Greenlane	10/06/2016
1547	ELH288	2008	Hyundai Getz	410-4223	Pt.Chevalier	
1549	ELH289	2008	Hyundai Getz	430-6001	Auckland Hospital	07/04/2016
1548	ELH295	2008	Hyundai Getz	410-3636	Greenlane	
1550	ELK655	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1555	ELT798	2008	Hyundai Getz	445-4634	Manawanui	
1556	EMD901	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1557	EMD902	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1558	EMD903	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1559	EMD904	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1560	EMD905	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1561	EMD906	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1562	EMD907	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1563	EMD908	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1564	EMD909	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1565	EMD910	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1567	EMY209	2008	Hyundai Getz	415-2020	Auckland Hospital	
1568	EMY210	2008	Hyundai Getz	455-8516	Greenlane	05/04/2016
1569	EMY211	2008	Hyundai Getz	445-4643	Morningside	27/03/2017
1566	EMY213	2008	Hyundai Getz	415-3646	Greenlane	
1571	EPL469	2008	Ford Transit	420-4246	Greenlane	
1575	ERK447	2008	Hyundai Getz	420-4246	Greenlane	
1574	ERK448	2008	Hyundai Getz	420-4246	Greenlane	
1573	ERK449	2008	Hyundai Getz	420-4246	Greenlane	

1572	ERK450	2008	Hyundai Getz	420-4246	Greenlane	
1576	ERP983	2008	Hyundai Getz	420-4246	Greenlane	
1577	ERR110	2008	Nissan Wingroad S/W	420-4246	Greenlane	
1354	ESC686	2006	Hyundai Getz	445-4635	Greenlane	12/08/2015
1582	ETS863	2009	Nissan Urvan	430-5343	Auckland Hospital	
1580	ETS865	2009	Nissan Wingroad S/W	420-4246	Greenlane	
1579	ETS866	2009	Nissan Wingroad S/W	420-4246	Greenlane	
1578	ETS867	2009	Nissan Wingroad S/W	420-4246	Greenlane	14/10/2015
1524	ETW467	2008	Hyundai Getz	445-4637	Greenlane	
1764	EUJ792	2008	Hyundai Getz	420-4241	Greenlane	
1758	EUJ794	2008	Hyundai Getz	445-4633	Taylor Centre	
1759	EUW326	2009	Hyundai Getz	445-4633	Taylor Centre	
1763	EWL470	2009	Hyundai Getz	420-4246	Greenlane	
1766	EWZ911	2009	Hyundai Getz	420-4241	Greenlane	11/08/2017
1762	EWZ916	2009	Hyundai Getz	420-4246	Greenlane	
1589	EYK550	2009	Hyundai Getz	455-8514	Greenlane	
1586	EYK551	2009	Hyundai Getz	445-4635	Manawanui	
1591	EYK552	2009	Hyundai Getz	455-8516	Greenlane	07/04/2016
1606	EYK552	2009	Hyundai Getz	455-8516	Greenlane	05/04/2016
1592	EYK553	2009	Hyundai Getz	455-8514	Greenlane	
1595	EYK554	2009	Hyundai Getz	455-8514	Greenlane	
1584	EYK555	2009	Hyundai Getz	455-8514	Greenlane	
1593	EYK557	2009	Hyundai Getz	455-8514	Greenlane	05/09/2016
1590	EYK558	2009	Hyundai Getz	445-4633	Taylor Centre	
1761	EYK584	2009	Hyundai Getz	430-6001	Greenlane Hospital	
1585	EYK598	2009	Hyundai Getz	420-4246	Greenlane	
1588	EYK599	2009	Hyundai Getz	445-4633	Taylor Centre	
1587	EYK600	2009	Hyundai Getz	445-4633	Taylor Centre	
1596	EYU95	2009	Hyundai Getz	455-8514	Greenlane	06/12/2016
1597	EYU96	2009	Hyundai Getz	420-4246	Greenlane	
1598	EYU97	2009	Hyundai Getz	420-4246	Greenlane	03/11/2014
1599	EYU98	2009	Hyundai Getz	455-8516	Greenlane	05/04/2016
1600	EYU99	2009	Hyundai Getz	420-4246	Greenlane	
1610	EZD602	2009	Nissan Wingroad S/W	410-4227	Greenlane	
1601	EZD903	2009	Hyundai Getz	455-8514	Greenlane	06/12/2016
1602	EZJ559	2009	Hyundai Getz	455-8514	Greenlane	
1603	EZJ560	2009	Hyundai Getz	410-4223	54,Carrington Rd.	
1604	EZJ561	2009	Hyundai Getz	455-8516	Greenlane	05/04/2016
1605	EZJ562	2009	Hyundai Getz	455-8514	Greenlane	
1607	EZJ564	2009	Hyundai Getz	455-8514	Greenlane	06/12/2016
1608	EZJ565	2009	Hyundai Getz	455-8516	Greenlane	07/04/2016
1609	EZJ566	2009	Hyundai Getz	420-4246	Greenlane	
1611	EZU776	2009	Hyundai Getz	445-4505	Greenlane	

1612	EZU777	2009	Hyundai Getz	410-4227	Greenlane	
1613	EZU778	2009	Hyundai Getz	410-4227	Greenlane	
1614	EZU779	2009	Hyundai Getz	410-4227	Greenlane	
1615	FAC249	2009	Hyundai Getz	445-4626	Panmure	
1616	FAC250	2009	Hyundai Getz	410-4222	Greenlane	
1617	FAC251	2009	Hyundai Getz	445-4627	Morningside	
1618	FAC252	2009	Hyundai Getz	445-4637	Greenlane	
1619	FAC253	2009	Hyundai Getz	445-4637	Greenlane	
1620	FAC254	2009	Hyundai Getz	445-4637	Greenlane	
1760	FAC255	2009	Hyundai Getz	430-6001	Greenlane	
1621	FAL581	2009	Hyundai Getz	445-4628	Greenlane	
1622	FAU41	2009	Hyundai Getz	410-4227	Greenlane	
1623	FAU61	2009	Hyundai Getz	410-4227	Greenlane	
1624	FAU62	2009	Hyundai Getz	410-4227	Greenlane	
1625	FAU63	2009	Hyundai Getz	410-4227	Greenlane	
1626	FAU64	2009	Hyundai Getz	410-4227	Greenlane	
1627	FAU65	2009	Hyundai Getz	410-4227	Greenlane	
1628	FAU66	2009	Hyundai Getz	410-4227	Greenlane	
1629	FAU67	2009	Hyundai Getz	410-4227	Greenlane	22/09/2014
1630	FAU68	2009	Hyundai Getz	410-4227	Greenlane	
1631	FAU69	2009	Hyundai Getz	410-4227	Greenlane	
1632	FAU70	2009	Hyundai Getz	410-4227	Greenlane	
1633	FAU71	2009	Hyundai Getz	410-4227	Greenlane	
1634	FBU225	2009	Hyundai i30	420-4246	Greenlane	
1635	FBU226	2009	Hyundai Getz	410-4227	Greenlane	
1636	FBU227	2009	Hyundai Getz	410-4227	Greenlane	
1637	FBU228	2009	Hyundai Getz	410-4227	Greenlane	
1638	FBU229	2009	Hyundai Getz	410-4227	Greenlane	
1639	FBU233	2009	Hyundai Tuscon AWD	455-8514	Greenlane	
1765	FDH159	2009	Hyundai Getz	420-4241	Greenlane	
1640	FEL649	2010	Mercedes Benz Sprinter	450-8915	Greenlane	
1642	FFC632	2010	Mercedes Benz Sprinter	450-8915	Sylvia Park	
1641	FFL670	2010	Hyundai i30 S/W	430-5631	Auckland Hospital	
1643	FJP647	2010	Isuzu NPR450L	450-8200	Auckland Hospital	28/04/2015
1648	FKS992	2010	Hyundai Getz	445-4637	Greenlane	
1647	FKS993	2010	Hyundai Getz	420-4237	Auckland Hospital	
1646	FKS994	2010	Hyundai Getz	445-4635	Greenlane	
1645	FKS995	2010	Hyundai Getz	415-3646	Greenlane	
1644	FKS996	2010	Hyundai Getz	415-3646	Auckland Hospital	
1649	FML964	2010	Mercedes Benz Sprinter	450-8915	Avondale	
1650	FQB564	2010	Hyundai Getz	410-4227	Greenlane	
1651	FQB565	2010	Hyundai Getz	410-4227	Greenlane	29/07/2015
1652	FQB566	2010	Hyundai Getz	410-4227	Greenlane	

1653	FQB567	2010	Hyundai Getz	455-8514	Greenlane	
1654	FQB568	2010	Hyundai Getz	410-4222	Greenlane	
1655	FQB569	2010	Hyundai Getz	445-4626	Panmure	
1656	FQB570	2010	Hyundai Getz	445-4627	Morningside	
1799	FQB571	2010	Hyundai Getz	445-4625	Greenlane	
1658	FQB572	2010	Hyundai Getz	445-4643	Morningside	
1659	FQB573	2010	Hyundai Getz	445-4633	Taylor Centre	
1660	FQB574	2010	Hyundai Getz	445-4635	Greenlane	
1661	FQB575	2010	Hyundai Getz	445-4635	Greenlane	
1535	FRC403	2008	Hyundai Getz	445-2030	27,Sutherland Rd.	
1662	FRP511	2010	Hyundai Getz	445-4633	Waiheke Isl	
1663	FRP512	2010	Hyundai Getz	445-4637	Greenlane	05/04/2016
1664	FRP513	2010	Hyundai Getz	420-4246	Greenlane	
1665	FRP514	2010	Hyundai Getz	420-4246	Greenlane	
1666	FRP515	2010	Hyundai Getz	420-4246	Greenlane	
1667	FRP516	2010	Hyundai Getz	420-4246	Greenlane	
1668	FRP517	2010	Hyundai Getz	420-4246	Greenlane	
1669	FRP518	2010	Hyundai Getz	420-4246	Greenlane	
1670	FRP519	2010	Hyundai Getz	445-4625	Greenlane	
1671	FRP520	2010	Hyundai Getz	445-4625	Greenlane	
1673	FRP521	2010	Hyundai Getz	445-4626	Panmure	
1672	FRP522	2010	Hyundai Getz	445-4625	Greenlane	
1685	FSJ981	2011	Hyundai Getz	445-4633	Taylor Centre	
1684	FSJ982	2011	Hyundai Getz	445-4633	Taylor Centre	
1683	FSJ983	2011	Hyundai Getz	445-4627	Morningside	
1682	FSJ984	2011	Hyundai Getz	445-4627	Morningside	
1681	FSJ985	2011	Hyundai Getz	420-4246	Greenlane	
1680	FSJ986	2011	Hyundai Getz	420-4246	Greenlane	
1679	FSJ987	2011	Hyundai Getz	420-4246	Greenlane	
1678	FSJ988	2011	Hyundai Getz	420-4246	Greenlane	
1677	FSJ989	2011	Hyundai Getz	420-4246	Greenlane	
1676	FSJ990	2011	Hyundai Getz	420-4246	Greenlane	
1675	FSJ991	2011	Hyundai Getz	410-4227	Greenlane	
1674	FSK20	2011	Hyundai Getz	410-4227	Greenlane	
1699	FTD100	2011	Hyundai Getz	445-4626	Panmure	
1686	FTD104	2011	Hyundai Getz	410-4227	Greenlane	
1687	FTD105	2011	Hyundai Getz	410-4227	Greenlane	22/07/2015
1688	FTD89	2011	Hyundai Getz	410-4227	Greenlane	
1689	FTD90	2011	Hyundai Getz	410-4227	Greenlane	
1690	FTD91	2011	Hyundai Getz	410-4227	Greenlane	
1691	FTD92	2011	Hyundai Getz	410-4223	Pt.Chevalier	
1692	FTD93	2011	Hyundai Getz	410-4227	Greenlane	
1693	FTD94	2011	Hyundai Getz	420-4246	Greenlane	
1694	FTD95	2011	Hyundai Getz	420-4246	Greenlane	
1695	FTD96	2011	Hyundai Getz	420-4246	Greenlane	
1696	FTD97	2011	Hyundai Getz	420-4246	Greenlane	

1697	FTD98	2011	Hyundai Getz	445-4626	Panmure	
1698	FTD99	2011	Hyundai Getz	445-4626	Panmure	
1702	FUL165	2011	Hyundai i30 S/W	420-4246	Greenlane	
1700	FUL166	2011	Hyundai i30 S/W	410-4227	Greenlane	
1701	FUL167	2011	Hyundai i30 S/W	410-4227	Greenlane	
1715	FWM180	2011	Mercedes Benz Sprinter	450-8915	Sylvia Park	
1703	FYC70	2011	Hyundai Getz	445-4626	Panmure	
1704	FYC71	2011	Hyundai Getz	445-4627	Morningside	
1705	FYC72	2011	Hyundai Getz	445-4627	Morningside	
1706	FYC73	2011	Hyundai Getz	445-4627	Morningside	
1707	FYC74	2011	Hyundai Getz	445-4627	Morningside	
1709	FYC75	2011	Hyundai Getz	445-4633	Taylor Centre	
1708	FYC76	2011	Hyundai Getz	445-4627	Morningside	19/10/2016
1710	FYC77	2011	Hyundai Getz	445-4635	Greenlane	
1711	FYC78	2011	Hyundai Getz	445-4635	Greenlane	
1712	FYC79	2011	Hyundai Getz	415-3646	Greenlane	
1713	FYC80	2011	Hyundai Getz	415-3646	Greenlane	
1714	FYC81	2011	Hyundai Getz	430-6001	Greenlane	
1716	GCH831	2011	Hyundai i20	445-4625	Greenlane	
1717	GCH832	2011	Hyundai i20	445-4625	Greenlane	
1718	GCH833	2011	Hyundai i20	410-4227	Greenlane	
1719	GCH834	2011	Hyundai i20	410-4227	Greenlane	
1720	GCH835	2011	Hyundai i20	410-4227	Greenlane	
1721	GCH836	2011	Hyundai i20	410-4227	Greenlane	
1722	GCH842	2011	Hyundai i20	410-4227	Greenlane	
1723	GCH843	2011	Hyundai i20	410-4227	Greenlane	
1724	GCH844	2011	Hyundai i20	410-4227	Greenlane	
1725	GCH845	2011	Hyundai i20	410-4227	Greenlane	
1743	GFJ474	2012	Hyundai i30 S/W	450-8243	Greenlane	16/04/2015
1734	GFP401	2012	Hyundai i20	410-4227	Greenlane	
1735	GFP402	2012	Hyundai i20	420-4246	Greenlane	
1732	GFP403	2012	Hyundai i20	410-4227	Greenlane	
1731	GFP404	2012	Hyundai i20	410-4227	Greenlane	
1728	GFP405	2012	Hyundai i20	410-4227	Greenlane	
1730	GFP406	2012	Hyundai i20	410-4227	Greenlane	
1736	GFP407	2012	Hyundai i20	420-4246	Greenlane	
1729	GFP408	2012	Hyundai i20	410-4227	Greenlane	
1733	GFP409	2012	Hyundai i20	410-4227	Greenlane	
1727	GFP410	2012	Hyundai i20	410-4227	Greenlane	
1744	GGZ920	2012	Hyundai i20	410-4227	Greenlane	
1745	GHT500	2012	Mercedes Benz Sprinter	450-8915	Greenlane	
1746	GJN182	2012	Mercedes Benz Sprinter	450-8915	Sandringham	
1747	GPF169	2012	Toyota Hilux 3.0.TD	455-8514	Greenlane	
1768	GUZ903	2013	Hyundai i20	420-4241	Greenlane	

1769	GUZ904	2013	Hyundai i20	445-4625	Greenlane	
1770	GUZ905	2013	Hyundai i20	445-4625	Greenlane	
1771	GUZ906	2013	Hyundai i20	445-4625	Greenlane	
1772	GUZ907	2013	Hyundai i20	420-4246	Greenlane	
1773	GUZ908	2013	Hyundai i20	415-2020	Auckland Hospital	
1774	GUZ909	2013	Hyundai i20	445-4633	Taylor Centre	
1775	GUZ910	2013	Hyundai i20	445-4633	Taylor Centre	
1776	GUZ911	2013	Hyundai i20	420-3111	Grafton	
1778	GUZ913	2013	Hyundai i20	415-3646	Greenlane	
1779	GUZ914	2013	Hyundai i20	415-3646	Greenlane	
1780	GUZ915	2013	Hyundai i20	410-4227	Greenlane	
1781	GUZ916	2013	Hyundai i20	410-4227	Greenlane	
1782	GUZ917	2013	Hyundai i20	410-4227	Greenlane	
1784	GWN703	2013	Toyota Corolla S/W	445-4637	Greenlane	
1783	GWT179	2013	Hyundai i20	445-4637	Greenlane	
1148	HCD6	2005	Ford Econovan	450-8200	Auckland Hospital	28/04/2015
1786	HCY632	2013	Hyundai Accent	445-4627	Morningside	
1785	HCY633	2013	Hyundai Accent	410-4226	Auckland Hospital	
1795	HFG156	2014	Hyundai i20	410-4227	Greenlane	
1788	HFP233	2014	Holden Cruze S/W	420-4246	Greenlane	
1787	HFP234	2014	Holden Cruze S/W	420-4246	Greenlane	
1789	HFP235	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1790	HFP236	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1791	HFP237	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1792	HFP238	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1793	HFP239	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1794	HFP240	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1796	HHL489	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1797	HHL491	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1798	HHL492	2014	Holden Cruze S/W	410-4222	Greenlane	
1801	HHL493	2014	Holden Cruze S/W	445-4643	Morningside	
1802	HHL494	2014	Holden Cruze S/W	445-4639	Greenlane	
1803	HHL495	2014	Holden Cruze S/W	420-4233	Greenlane	
1804	HHL496	2014	Holden Cruze S/W	445-4639	Greenlane	
1805	HHL497	2014	Holden Cruze S/W	445-4633	Taylor Centre	
1806	HJH715	2014	Hyundai Accent	410-4227	Greenlane	
1810	HJH716	2014	Hyundai Accent	445-4633	Taylor Centre	
1808	HJH717	2014	Hyundai i20	410-4227	Greenlane	
1811	HJH718	2014	Hyundai Accent	410-3044	Greenlane	
1809	HJH719	2014	Hyundai Accent	445-4505	Greenlane	
1807	HJH720	2014	Hyundai Accent	410-4227	Greenlane	
1820	HLM80	2014	Mercedes Benz Sprinter	420-4246	Greenlane	
1821	HNF128	2014	Mercedes Benz Sprinter	420-4246	Greenlane	
1822	HPA212	2014	Hyundai Accent	445-4635	Greenlane	

1830	HPA213	2014	Hyundai Accent	445-4626	Panmure	
1828	HPA247	2014	Hyundai i20	445-4643	Morningside	
1829	HPA248	2014	Hyundai i20	445-4643	Morningside	
1826	HPA249	2014	Hyundai i20	410-4227	Greenlane	
1827	HPA250	2014	Hyundai i20	410-4227	Greenlane	
1823	HPA251	2014	Hyundai i20	445-4635	Greenlane	
1824	HPA252	2014	Hyundai i20	420-4246	Greenlane	
1825	HPA253	2014	Hyundai i20	420-4246	Greenlane	
1840	HUM831	2015	Holden Cruze S/W	445-4635	Greenlane	
1839	HUM832	2015	Holden Cruze S/W	445-4633	Taylor Centre	
1835	HUM833	2015	Holden Cruze S/W	445-4627	Morningside	
1834	HUY669	2015	Toyota HiAce ZL	430-5631	Auckland Hospital	
1842	HWA470	2015	Hyundai i20	445-4635	Greenlane	
1837	HWA471	2015	Hyundai i20	445-4627	Morningside	
1841	HWA473	2015	Hyundai i20	445-4635	Greenlane	
1838	HWA474	2015	Hyundai i20	445-4627	Morningside	
1843	HWA475	2015	Hyundai Accent	445-4635	Greenlane	
1836	HWA476	2015	Hyundai Accent	445-4627	Morningside	
1833	HYP346	2015	Hyundai i20	410-4227	Greenlane	
1845	HYU519	2015	Hyundai i20	410-4223	54,Carrington Road	
1846	HYU520	2015	Hyundai i20	410-4227	Greenlane	
1851	HYU521	2015	Hyundai i20	420-4246	Greenlane	
1852	HYU522	2015	Hyundai i20	420-4246	Greenlane	
1844	HYU523	2015	Hyundai i20	410-3636	Greenlane	
1854	HYU579	2015	Hyundai i20	420-4246	Greenlane	
1847	HYZ774	2015	Holden Barina 1.6	410-4227	Greenlane	16/10/2017
1848	HYZ775	2015	Holden Barina 1.6	410-4227	Greenlane	
1849	HYZ776	2015	Holden Barina 1.6	420-4237	Greenlane	
1850	HYZ778	2015	Holden Barina 1.6	420-4246	Greenlane	
1853	HYZ779	2015	Holden Cruze S/W	420-4246	Greenlane	
1858	JAA941	2015	Hyundai Accent	445-4625	Greenlane	
1859	JAA942	2015	Hyundai i20	445-4626	Panmure	
1860	JAA943	2015	Hyundai i20	445-4626	Panmure	
1857	JAA944	2015	Hyundai i20	445-4625	Greenlane	
1861	JAA945	2015	Hyundai Accent	445-4639	Greenlane	
1855	JAL365	2015	Holden Cruze S/W	430-5631	Auckland Hospital	
1856	JAL367	2015	Holden Cruze S/W	445-2029	Auckland Hospital	
1800	JGR998	2014	Holden Cruze S/W	445-4643	Morningside	
1767	KDC795	2013	Hyundai Imax 8 seat	445-4634	Manawanui	
6800	TB7719	1994	LEYLAND LDV400	23133C	Rehab Plus	
1345	WT3227	1998	Mitsubishi Fuso	450-8200	Auckland Hospital	28/04/2015
1813	YR2018	1999	Toyota Corolla S/W	450-8243	Middlemore	16/04/2015
1812	YR5621	1999	Toyota Corolla S/W	450-8243	Waitakere	16/04/2015

Vehicles

2013/201

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Fleet Number	Registration Number	Registration Year	Make and model	RC Number	Location	Decommissioned
9337	AAE489	2001	Ford Transit	420-4246	Greenlane	24/09/2014
1486	ALC239	2001	Toyota Hiace	450-8243	Greenlane	16/04/2015
1490	ALQ457	2002	Toyota Hiace ZR	410-4223	54,Carrington Rd.	
1489	AME361	2002	Toyota Hiace ZR	430-5631	Greenlane Hospital	
1488	AME362	2002	Toyota Hiace	430-5631	Auckland Hospital	22/10/2014
1484	ANW956	2002	Toyota Hiace ZL	445-2030	27,Sutherland Rd.	
1485	ANW960	2002	Toyota Hiace ZL	445-2030	27,Sutherland Rd.	
1080	BAL235	2002	Toyota Hiace ZX	410-4223	54,Carrington Rd.	
1158	BJB204	2003	Toyota Corolla S/W	410-4227	Greenlane	24/04/2014
1157	BJB205	2003	Toyota Corolla S/W	420-4246	Greenlane	17/02/2014
1165	BJM699	2003	Toyota Hiace ZL	445-4639	Greenlane	03/05/2016
1068	BJU595	2003	Toyota Hiace ZL	445-2031	SSH	
1117	BTD456	2004	Toyota Corolla S/W	410-4223	54,Carrington Rd.	13/03/2014
1044	BTD457	2004	Toyota Corolla S/W	410-4223	54,Carrington Rd.	05/02/2014
1366	BTD458	2004	Toyota Corolla S/W	445-4643	Morningside	13/03/2014
1109	BTD459	2004	Toyota Corolla S/W	410-3044	Greenlane	24/04/2014
1047	BTJ341	2004	Toyota Corolla S/W	410-4223	54,Carrington Rd.	05/02/2014
1043	BTJ342	2004	Toyota Corolla S/W	410-4223	54,Carrington Rd.	05/02/2014
1048	BTJ344	2004	Toyota Corolla S/W	410-4222	Greenlane	18/03/2014
1045	BTJ345	2004	Toyota Corolla S/W	410-4223	54,Carrington Rd.	05/02/2014
1383	BTJ346	2004	Toyota Corolla S/W	410-4226	Auckland Hospital	15/11/2013
1042	BTJ347	2004	Toyota Corolla S/W	410-4223	54,Carrington Rd.	05/02/2014
1052	BTJ351	2004	Toyota Hiace ZL	445-4636	Buchanan Clinic	
1041	BTJ354	2004	Toyota Corolla S/W	410-4223	54,Carrington Rd.	05/02/2014
1056	BTJ361	2004	Daihatsu Sirion	450-8553	Greenlane	20/02/2015
1046	BTJ364	2004	Toyota Corolla S/W	420-4246	Greenlane	24/01/2014
1477	BWU535	2004	Toyota Corolla S/W	445-4639	Greenlane	19/03/2014
1480	BWU536	2004	Toyota Corolla S/W	445-4627	Morningside	14/01/2015
1479	BWU537	2004	Toyota Corolla S/W	445-4627	Morningside	18/02/2015
1748	BWU538	2004	Toyota Corolla S/W	445-4639	Greenlane	18/03/2014
1478	BYD902	2004	Toyota Corolla	420-4233	Greenlane	17/03/2014
1122	CAK227	2004	Toyota Corolla	445-4505	Greenlane	24/04/2014
1124	CBE260	2004	Toyota Corolla S/W	445-4643	Morningside	20/03/2014
1103	CBH901	2004	Toyota Corolla	445-4635	Greenlane	09/03/2015

			S/W			
1757	CBH902	2004	Toyota Corolla S/W	445-4633	Taylor Centre	19/03/2014
1107	CBH907	2004	Toyota Corolla S/W	445-4633	Taylor Centre	18/02/2015
1127	CGZ407	2004	Toyota Corolla S/W	410-4223	54,Carrington Rd.	13/03/2014
1126	CGZ439	2004	Toyota Corolla	410-4227	Greenlane	24/04/2014
1451	CLS716	2005	Toyota Corolla S/W	445-2029	Auckland Hospital	08/04/2015
1075	CQH303	2005	Hyundai Getz	420-4246	Greenlane	09/03/2015
1450	CRK146	2005	Toyota Corolla	445-4625	Greenlane	09/04/2015
1814	CRS703	2007	Hyundai Getz	450-8243	Takapuna	16/04/2015
1276	CSL971	2005	Hyundai Getz	445-4626	Panmure	08/04/2015
1753	CSQ292	2005	Hyundai Getz	420-4246	Greenlane	10/03/2015
1368	CYN875	2005	Hyundai Getz	410-4223	54,Carrington Rd.	09/03/2015
1815	CZL14	2005	Mitsubishi Lancer S/W	450-8243	Middlemore	16/04/2015
1394	DAM367	2005	Toyota Corolla S/W	430-5631	Auckland Hospital	07/04/2015
1385	DBN301	2005	Hyundai Getz	410-4220	Greenlane	09/03/2015
1386	DBN302	2005	Hyundai Getz	420-4246	Greenlane	26/08/2014
1387	DBN303	2005	Hyundai Getz	420-4237	Auckland Hospital	10/03/2015
1388	DBN304	2005	Hyundai Getz	420-4246	Greenlane	09/03/2015
1389	DBN305	2005	Hyundai Getz	410-4227	Greenlane	09/03/2015
1390	DBN306	2005	Hyundai Getz	445-4626	Panmure	20/08/2015
1391	DBN307	2005	Hyundai Getz	445-4626	Panmure	07/04/2015
1392	DBN309	2005	Hyundai Getz	445-4634	Greenlane	04/08/2015
1393	DBN310	2005	Hyundai Getz	445-4635	Greenlane	14/01/2015
1442	DBN311	2005	Hyundai Getz	445-4635	Greenlane	14/01/2014
1752	DBN313	2005	Hyundai Getz	420-4246	Greenlane	26/08/2014
1152	DBN315	2005	Hyundai Getz	445-4627	Morningside	14/01/2015
1444	DBN316	2005	Hyundai Getz	445-4643	Morningside	26/08/2014
1419	DBN318	2005	Hyundai Getz	445-4627	Morningside	14/01/2015
1420	DBN320	2005	Hyundai Getz	410-4227	Greenlane	26/08/2014
1755	DBN321	2005	Hyundai Getz	410-4227	Greenlane	10/03/2015
1417	DBQ564	2005	Toyota Corolla	445-4627	Morningside	20/11/2013
1418	DBQ565	2005	Toyota Corolla	445-4633	Taylor Centre	24/04/2014
1423	DBW382	2005	Hyundai Getz	445-4625	Greenlane	08/04/2015
1441	DCK203	2005	Nissan Pulsar S/W	420-4246	Greenlane	10/03/2015
1334	DNK418	2006	Hyundai Getz	445-4635	Greenlane	12/08/2015
1332	DNK420	2006	Hyundai Getz	445-4635	Greenlane	25/08/2014
1331	DNK421	2006	Hyundai Getz	445-4627	Morningside	20/08/2015
1251	DNK422	2006	Hyundai Getz	445-4627	Morningside	12/08/2015
1355	DNK423	2006	Hyundai Getz	445-4626	Panmure	
1353	DNK424	2006	Hyundai Getz	445-4626	Panmure	
1252	DNK425	2006	Hyundai Getz	445-4633	Taylor Centre	09/06/2016
1425	DNU448	2006	Hyundai Getz	415-3646	Greenlane	
1426	DPS864	2006	Nissan Tiida	445-4626	Panmure	26/08/2014

1427	DPS875	2006	Nissan Tiida	445-4635	Greenlane	25/08/2014
1428	DPS882	2006	Nissan Tiida	445-4639	Greenlane	07/04/2015
1754	DQP184	2006	Hyundai Getz	410-4227	Greenlane	10/03/2015
1351	DQR417	2006	Nissan Tiida	445-4635	Greenlane	22/09/2014
1817	DTP686	2007	Toyota Corolla S/W	450-8243	WDHB	29/07/2014
1818	DTP687	2007	Toyota Corolla S/W	450-8243	HAH	16/04/2015
1501	DWW348	2007	Mitsubishi L300	445-4637	218,Gt.South Road	
1816	DWW364	2007	Mitsubishi Lancer	450-8243		16/04/2015
1502	DZS404	2007	Hyundai Getz	410-4223	54,Carrington Rd.	
1504	EAN617	2007	Nissan Tiida	445-4639	Greenlane	13/05/2016
1503	EAQ333	2007	Mitsubishi Fuso	430-6001	Auckland Hospital	
1505	ECM799	2007	Hyundai Getz	445-4626	Panmure	
1506	ECP855	2007	Hyundai Getz	410-4227	Greenlane	09/06/2016
1507	ECT993	2007	Hyundai Getz	445-4505	Greenlane	
1508	ECU950	2007	Holden Viva S/W	445-2028	Auckland Hospital	05/08/2015
1511	EDQ846	2007	Hyundai Getz	410-4227	Greenlane	05/04/2016
1756	EDR67	2007	Hyundai Getz	410-4227	Greenlane	10/06/2016
1518	EDR68	2007	Hyundai Getz	445-4639	Greenlane	13/05/2016
1516	EDR69	2007	Hyundai Getz	410-4227	Greenlane	26/08/2014
1515	EDR70	2007	Hyundai Getz	445-4636	27,Sutherland Rd.	
1514	EDR75	2007	Hyundai Getz	445-4634	Manawanui	
1513	EDR76	2007	Hyundai Getz	445-4634	Manawanui	
1512	EDR77	2007	Hyundai Getz	445-4634	Manawanui	
1519	EDR78	2007	Hyundai Getz	445-4643	Morningside	26/08/2014
1510	EDR79	2007	Hyundai Getz	445-4627	Morningside	
1509	EDR81	2007	Hyundai Getz	445-2028	Auckland Hospital	
1520	EDT377	2007	Nissan Wingroad S/W	450-6009	Auckland Hospital	
1333	EFG468	2006	Hyundai Getz	445-4633	Waiheke Isl	
1522	EFK552	2007	Hyundai Getz	445-4635	Greenlane	
1521	EFK553	2007	Hyundai Getz	445-4635	Greenlane	
1523	EJA39	2008	Hyundai Getz	455-8516	Greenlane	07/04/2016
1525	EJD640	2008	Nissan Wingroad S/W	455-8516	Greenlane	13/05/2016
1527	EJR580	2008	Hyundai Getz	455-8514	Greenlane	
1526	EJR581	2008	Hyundai Getz	455-8514	Greenlane	
1551	EKC537	2008	Holden Viva S/W	430-6001	Auckland Hospital	15/11/2017
1552	EKC538	2008	Holden Viva S/W	430-6001	Auckland Hospital	
1554	EKC539	2008	Holden Viva S/W	430-6001	Auckland Hospital	
1553	EKC540	2008	Holden Viva S/W	430-6001	Auckland Hospital	
1539	EKC641	2008	Nissan Wingroad S/W	455-8516	Greenlane	13/05/2016
1540	EKC642	2008	Nissan Wingroad S/W	410-4223	54,Carrington Rd	

1538	EKC672	2008	Nissan Urvan	410-4227	Greenlane	
1541	EKC679	2008	Nissan Wingroad S/W	420-4246	Greenlane	
1542	EKC680	2008	Nissan Wingroad S/W	430-5343	Auckland Hospital	
1533	EKG729	2008	Hyundai Getz	445-2030	27,Sutherland Rd.	
1534	EKG730	2008	Hyundai Getz	445-2030	27,Sutherland Rd.	
1531	EKG732	2008	Hyundai Getz	445-4636	Morningside	
1543	EKG733	2008	Hyundai Getz	455-8514	Greenlane	
1530	EKG734	2008	Hyundai Getz	455-8514	Greenlane	06/12/2016
1529	EKG735	2008	Hyundai Getz	455-8514	Greenlane	
1537	EKG736	2008	Hyundai Getz	455-8514	Greenlane	06/12/2016
1536	EKG737	2008	Hyundai Getz	455-8516	Greenlane	07/04/2016
1532	EKG739	2008	Hyundai Getz	455-8514	Greenlane	
1544	ELH285	2008	Hyundai Getz	455-8514	Greenlane	10/06/2016
1545	ELH286	2008	Hyundai Getz	445-4633	Taylor Centre	
1546	ELH287	2008	Hyundai Getz	455-8514	Greenlane	10/06/2016
1547	ELH288	2008	Hyundai Getz	410-4223	Pt.Chevalier	
1549	ELH289	2008	Hyundai Getz	430-6001	Auckland Hospital	07/04/2016
1548	ELH295	2008	Hyundai Getz	410-3636	Greenlane	
1550	ELK655	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1555	ELT798	2008	Hyundai Getz	445-4634	Manawanui	
1556	EMD901	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1557	EMD902	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1558	EMD903	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1559	EMD904	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1560	EMD905	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1561	EMD906	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1562	EMD907	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1563	EMD908	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1564	EMD909	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1565	EMD910	2008	Nissan Wingroad S/W	410-4227	Greenlane	
1567	EMY209	2008	Hyundai Getz	415-2020	Auckland Hospital	
1568	EMY210	2008	Hyundai Getz	455-8516	Greenlane	05/04/2016
1569	EMY211	2008	Hyundai Getz	445-4643	Morningside	27/03/2017
1566	EMY213	2008	Hyundai Getz	415-3646	Greenlane	
1571	EPL469	2008	Ford Transit	420-4246	Greenlane	
1575	ERK447	2008	Hyundai Getz	420-4246	Greenlane	
1574	ERK448	2008	Hyundai Getz	420-4246	Greenlane	
1573	ERK449	2008	Hyundai Getz	420-4246	Greenlane	
1572	ERK450	2008	Hyundai Getz	420-4246	Greenlane	
1576	ERP983	2008	Hyundai Getz	420-4246	Greenlane	

1577	ERR110	2008	Nissan Wingroad S/W	420-4246	Greenlane	
1354	ESC686	2006	Hyundai Getz	445-4635	Greenlane	12/08/2015
1749	ETS835	2008	Ford Transit	450-8243	Greenlane	16/04/2014
1582	ETS863	2009	Nissan Urvan	430-5343	Auckland Hospital	
1580	ETS865	2009	Nissan Wingroad S/W	420-4246	Greenlane	
1579	ETS866	2009	Nissan Wingroad S/W	420-4246	Greenlane	
1578	ETS867	2009	Nissan Wingroad S/W	420-4246	Greenlane	14/10/2015
1524	ETW467	2008	Hyundai Getz	445-4637	Greenlane	
1764	EUJ792	2008	Hyundai Getz	420-4241	Greenlane	
1758	EUJ794	2008	Hyundai Getz	445-4633	Taylor Centre	
1759	EUW326	2009	Hyundai Getz	445-4633	Taylor Centre	
1763	EWL470	2009	Hyundai Getz	420-4246	Greenlane	
1766	EWZ911	2009	Hyundai Getz	420-4241	Greenlane	11/08/2017
1762	EWZ916	2009	Hyundai Getz	420-4246	Greenlane	
1589	EYK550	2009	Hyundai Getz	455-8514	Greenlane	
1586	EYK551	2009	Hyundai Getz	445-4635	Manawanui	
1591	EYK552	2009	Hyundai Getz	455-8516	Greenlane	07/04/2016
1606	EYK552	2009	Hyundai Getz	455-8516	Greenlane	05/04/2016
1592	EYK553	2009	Hyundai Getz	455-8514	Greenlane	
1595	EYK554	2009	Hyundai Getz	455-8514	Greenlane	
1584	EYK555	2009	Hyundai Getz	455-8514	Greenlane	
1594	EYK556	2009	Hyundai Getz	455-8516	Greenlane	05/11/2013
1593	EYK557	2009	Hyundai Getz	455-8514	Greenlane	05/09/2016
1590	EYK558	2009	Hyundai Getz	445-4633	Taylor Centre	
1761	EYK584	2009	Hyundai Getz	430-6001	Greenlane Hospital	
1585	EYK598	2009	Hyundai Getz	420-4246	Greenlane	
1588	EYK599	2009	Hyundai Getz	445-4633	Taylor Centre	
1587	EYK600	2009	Hyundai Getz	445-4633	Taylor Centre	
1596	EYU95	2009	Hyundai Getz	455-8514	Greenlane	06/12/2016
1597	EYU96	2009	Hyundai Getz	420-4246	Greenlane	
1598	EYU97	2009	Hyundai Getz	420-4246	Greenlane	03/11/2014
1599	EYU98	2009	Hyundai Getz	455-8516	Greenlane	05/04/2016
1600	EYU99	2009	Hyundai Getz	420-4246	Greenlane	
1610	EZD602	2009	Nissan Wingroad S/W	410-4227	Greenlane	
1601	EZD903	2009	Hyundai Getz	455-8514	Greenlane	06/12/2016
1602	EZJ559	2009	Hyundai Getz	455-8514	Greenlane	
1603	EZJ560	2009	Hyundai Getz	410-4223	54,Carrington Rd.	
1604	EZJ561	2009	Hyundai Getz	455-8516	Greenlane	05/04/2016
1605	EZJ562	2009	Hyundai Getz	455-8514	Greenlane	
1607	EZJ564	2009	Hyundai Getz	455-8514	Greenlane	06/12/2016
1608	EZJ565	2009	Hyundai Getz	455-8516	Greenlane	07/04/2016
1609	EZJ566	2009	Hyundai Getz	420-4246	Greenlane	
1611	EZU776	2009	Hyundai Getz	445-4505	Greenlane	

1612	EZU777	2009	Hyundai Getz	410-4227	Greenlane	
1613	EZU778	2009	Hyundai Getz	410-4227	Greenlane	
1614	EZU779	2009	Hyundai Getz	410-4227	Greenlane	
1615	FAC249	2009	Hyundai Getz	445-4626	Panmure	
1616	FAC250	2009	Hyundai Getz	410-4222	Greenlane	
1617	FAC251	2009	Hyundai Getz	445-4627	Morningside	
1618	FAC252	2009	Hyundai Getz	445-4637	Greenlane	
1619	FAC253	2009	Hyundai Getz	445-4637	Greenlane	
1620	FAC254	2009	Hyundai Getz	445-4637	Greenlane	
1760	FAC255	2009	Hyundai Getz	430-6001	Greenlane	
1621	FAL581	2009	Hyundai Getz	445-4628	Greenlane	
1622	FAU41	2009	Hyundai Getz	410-4227	Greenlane	
1623	FAU61	2009	Hyundai Getz	410-4227	Greenlane	
1624	FAU62	2009	Hyundai Getz	410-4227	Greenlane	
1625	FAU63	2009	Hyundai Getz	410-4227	Greenlane	
1626	FAU64	2009	Hyundai Getz	410-4227	Greenlane	
1627	FAU65	2009	Hyundai Getz	410-4227	Greenlane	
1628	FAU66	2009	Hyundai Getz	410-4227	Greenlane	
1629	FAU67	2009	Hyundai Getz	410-4227	Greenlane	22/09/2014
1630	FAU68	2009	Hyundai Getz	410-4227	Greenlane	
1631	FAU69	2009	Hyundai Getz	410-4227	Greenlane	
1632	FAU70	2009	Hyundai Getz	410-4227	Greenlane	
1633	FAU71	2009	Hyundai Getz	410-4227	Greenlane	
1634	FBU225	2009	Hyundai i30	420-4246	Greenlane	
1635	FBU226	2009	Hyundai Getz	410-4227	Greenlane	
1636	FBU227	2009	Hyundai Getz	410-4227	Greenlane	
1637	FBU228	2009	Hyundai Getz	410-4227	Greenlane	
1638	FBU229	2009	Hyundai Getz	410-4227	Greenlane	
1639	FBU233	2009	Hyundai Tuscon AWD	455-8514	Greenlane	
1765	FDH159	2009	Hyundai Getz	420-4241	Greenlane	
1640	FEL649	2010	Mercedes Benz Sprinter	450-8915	Greenlane	
1642	FFC632	2010	Mercedes Benz Sprinter	450-8915	Sylvia Park	
1641	FFL670	2010	Hyundai i30 S/W	430-5631	Auckland Hospital	
1643	FJP647	2010	Isuzu NPR450L	450-8200	Auckland Hospital	28/04/2015
1648	FKS992	2010	Hyundai Getz	445-4637	Greenlane	
1647	FKS993	2010	Hyundai Getz	420-4237	Auckland Hospital	
1646	FKS994	2010	Hyundai Getz	445-4635	Greenlane	
1645	FKS995	2010	Hyundai Getz	415-3646	Greenlane	
1644	FKS996	2010	Hyundai Getz	415-3646	Auckland Hospital	
1649	FML964	2010	Mercedes Benz Sprinter	450-8915	Avondale	
1650	FQB564	2010	Hyundai Getz	410-4227	Greenlane	
1651	FQB565	2010	Hyundai Getz	410-4227	Greenlane	29/07/2015
1652	FQB566	2010	Hyundai Getz	410-4227	Greenlane	

1653	FQB567	2010	Hyundai Getz	455-8514	Greenlane	
1654	FQB568	2010	Hyundai Getz	410-4222	Greenlane	
1655	FQB569	2010	Hyundai Getz	445-4626	Panmure	
1656	FQB570	2010	Hyundai Getz	445-4627	Morningside	
1799	FQB571	2010	Hyundai Getz	445-4625	Greenlane	
1658	FQB572	2010	Hyundai Getz	445-4643	Morningside	
1659	FQB573	2010	Hyundai Getz	445-4633	Taylor Centre	
1660	FQB574	2010	Hyundai Getz	445-4635	Greenlane	
1661	FQB575	2010	Hyundai Getz	445-4635	Greenlane	
1535	FRC403	2008	Hyundai Getz	445-2030	27,Sutherland Rd.	
1662	FRP511	2010	Hyundai Getz	445-4633	Waiheke Isl	
1663	FRP512	2010	Hyundai Getz	445-4637	Greenlane	05/04/2016
1664	FRP513	2010	Hyundai Getz	420-4246	Greenlane	
1665	FRP514	2010	Hyundai Getz	420-4246	Greenlane	
1666	FRP515	2010	Hyundai Getz	420-4246	Greenlane	
1667	FRP516	2010	Hyundai Getz	420-4246	Greenlane	
1668	FRP517	2010	Hyundai Getz	420-4246	Greenlane	
1669	FRP518	2010	Hyundai Getz	420-4246	Greenlane	
1670	FRP519	2010	Hyundai Getz	445-4625	Greenlane	
1671	FRP520	2010	Hyundai Getz	445-4625	Greenlane	
1673	FRP521	2010	Hyundai Getz	445-4626	Panmure	
1672	FRP522	2010	Hyundai Getz	445-4625	Greenlane	
1685	FSJ981	2011	Hyundai Getz	445-4633	Taylor Centre	
1684	FSJ982	2011	Hyundai Getz	445-4633	Taylor Centre	
1683	FSJ983	2011	Hyundai Getz	445-4627	Morningside	
1682	FSJ984	2011	Hyundai Getz	445-4627	Morningside	
1681	FSJ985	2011	Hyundai Getz	420-4246	Greenlane	
1680	FSJ986	2011	Hyundai Getz	420-4246	Greenlane	
1679	FSJ987	2011	Hyundai Getz	420-4246	Greenlane	
1678	FSJ988	2011	Hyundai Getz	420-4246	Greenlane	
1677	FSJ989	2011	Hyundai Getz	420-4246	Greenlane	
1676	FSJ990	2011	Hyundai Getz	420-4246	Greenlane	
1675	FSJ991	2011	Hyundai Getz	410-4227	Greenlane	
1674	FSK20	2011	Hyundai Getz	410-4227	Greenlane	
1699	FTD100	2011	Hyundai Getz	445-4626	Panmure	
1686	FTD104	2011	Hyundai Getz	410-4227	Greenlane	
1687	FTD105	2011	Hyundai Getz	410-4227	Greenlane	22/07/2015
1688	FTD89	2011	Hyundai Getz	410-4227	Greenlane	
1689	FTD90	2011	Hyundai Getz	410-4227	Greenlane	
1690	FTD91	2011	Hyundai Getz	410-4227	Greenlane	
1691	FTD92	2011	Hyundai Getz	410-4223	Pt.Chevalier	
1692	FTD93	2011	Hyundai Getz	410-4227	Greenlane	
1693	FTD94	2011	Hyundai Getz	420-4246	Greenlane	
1694	FTD95	2011	Hyundai Getz	420-4246	Greenlane	
1695	FTD96	2011	Hyundai Getz	420-4246	Greenlane	
1696	FTD97	2011	Hyundai Getz	420-4246	Greenlane	

1697	FTD98	2011	Hyundai Getz	445-4626	Panmure	
1698	FTD99	2011	Hyundai Getz	445-4626	Panmure	
1702	FUL165	2011	Hyundai i30 S/W	420-4246	Greenlane	
1700	FUL166	2011	Hyundai i30 S/W	410-4227	Greenlane	
1701	FUL167	2011	Hyundai i30 S/W	410-4227	Greenlane	
1715	FWM180	2011	Mercedes Benz Sprinter	450-8915	Sylvia Park	
1703	FYC70	2011	Hyundai Getz	445-4626	Panmure	
1704	FYC71	2011	Hyundai Getz	445-4627	Morningside	
1705	FYC72	2011	Hyundai Getz	445-4627	Morningside	
1706	FYC73	2011	Hyundai Getz	445-4627	Morningside	
1707	FYC74	2011	Hyundai Getz	445-4627	Morningside	
1709	FYC75	2011	Hyundai Getz	445-4633	Taylor Centre	
1708	FYC76	2011	Hyundai Getz	445-4627	Morningside	19/10/2016
1710	FYC77	2011	Hyundai Getz	445-4635	Greenlane	
1711	FYC78	2011	Hyundai Getz	445-4635	Greenlane	
1712	FYC79	2011	Hyundai Getz	415-3646	Greenlane	
1713	FYC80	2011	Hyundai Getz	415-3646	Greenlane	
1714	FYC81	2011	Hyundai Getz	430-6001	Greenlane	
1716	GCH831	2011	Hyundai i20	445-4625	Greenlane	
1717	GCH832	2011	Hyundai i20	445-4625	Greenlane	
1718	GCH833	2011	Hyundai i20	410-4227	Greenlane	
1719	GCH834	2011	Hyundai i20	410-4227	Greenlane	
1720	GCH835	2011	Hyundai i20	410-4227	Greenlane	
1721	GCH836	2011	Hyundai i20	410-4227	Greenlane	
1722	GCH842	2011	Hyundai i20	410-4227	Greenlane	
1723	GCH843	2011	Hyundai i20	410-4227	Greenlane	
1724	GCH844	2011	Hyundai i20	410-4227	Greenlane	
1725	GCH845	2011	Hyundai i20	410-4227	Greenlane	
1743	GFJ474	2012	Hyundai i30 S/W	450-8243	Greenlane	16/04/2015
1734	GFP401	2012	Hyundai i20	410-4227	Greenlane	
1735	GFP402	2012	Hyundai i20	420-4246	Greenlane	
1732	GFP403	2012	Hyundai i20	410-4227	Greenlane	
1731	GFP404	2012	Hyundai i20	410-4227	Greenlane	
1728	GFP405	2012	Hyundai i20	410-4227	Greenlane	
1730	GFP406	2012	Hyundai i20	410-4227	Greenlane	
1736	GFP407	2012	Hyundai i20	420-4246	Greenlane	
1729	GFP408	2012	Hyundai i20	410-4227	Greenlane	
1733	GFP409	2012	Hyundai i20	410-4227	Greenlane	
1727	GFP410	2012	Hyundai i20	410-4227	Greenlane	
1744	GGZ920	2012	Hyundai i20	410-4227	Greenlane	
1745	GHT500	2012	Mercedes Benz Sprinter	450-8915	Greenlane	
1746	GJN182	2012	Mercedes Benz Sprinter	450-8915	Sandringham	
1747	GPF169	2012	Toyota Hilux 3.0.TD	455-8514	Greenlane	
1768	GUZ903	2013	Hyundai i20	420-4241	Greenlane	

1769	GUZ904	2013	Hyundai i20	445-4625	Greenlane	
1770	GUZ905	2013	Hyundai i20	445-4625	Greenlane	
1771	GUZ906	2013	Hyundai i20	445-4625	Greenlane	
1772	GUZ907	2013	Hyundai i20	420-4246	Greenlane	
1773	GUZ908	2013	Hyundai i20	415-2020	Auckland Hospital	
1774	GUZ909	2013	Hyundai i20	445-4633	Taylor Centre	
1775	GUZ910	2013	Hyundai i20	445-4633	Taylor Centre	
1776	GUZ911	2013	Hyundai i20	420-3111	Grafton	
1777	GUZ912	2013	Hyundai i20	410-4227	Greenlane	28/11/2013
1778	GUZ913	2013	Hyundai i20	415-3646	Greenlane	
1779	GUZ914	2013	Hyundai i20	415-3646	Greenlane	
1780	GUZ915	2013	Hyundai i20	410-4227	Greenlane	
1781	GUZ916	2013	Hyundai i20	410-4227	Greenlane	
1782	GUZ917	2013	Hyundai i20	410-4227	Greenlane	
1784	GWN703	2013	Toyota Corolla S/W	445-4637	Greenlane	
1783	GWT179	2013	Hyundai i20	445-4637	Greenlane	
1148	HCD6	2005	Ford Econovan	450-8200	Auckland Hospital	28/04/2015
1786	HCY632	2013	Hyundai Accent	445-4627	Morningside	
1785	HCY633	2013	Hyundai Accent	410-4226	Auckland Hospital	
1795	HFG156	2014	Hyundai i20	410-4227	Greenlane	
1788	HFP233	2014	Holden Cruze S/W	420-4246	Greenlane	
1787	HFP234	2014	Holden Cruze S/W	420-4246	Greenlane	
1789	HFP235	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1790	HFP236	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1791	HFP237	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1792	HFP238	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1793	HFP239	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1794	HFP240	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1796	HHL489	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1797	HHL491	2014	Holden Cruze S/W	410-4223	54,Carrington Rd.	
1798	HHL492	2014	Holden Cruze S/W	410-4222	Greenlane	
1801	HHL493	2014	Holden Cruze S/W	445-4643	Morningside	
1802	HHL494	2014	Holden Cruze S/W	445-4639	Greenlane	
1803	HHL495	2014	Holden Cruze S/W	420-4233	Greenlane	
1804	HHL496	2014	Holden Cruze S/W	445-4639	Greenlane	
1805	HHL497	2014	Holden Cruze S/W	445-4633	Taylor Centre	
1806	HJH715	2014	Hyundai Accent 5DHB	410-4227	Greenlane	
1810	HJH716	2014	Hyundai Accent	445-4633	Taylor Centre	
1808	HJH717	2014	Hyundai i20	410-4227	Greenlane	
1811	HJH718	2014	Hyundai Accent	410-3044	Greenlane	
1809	HJH719	2014	Hyundai Accent	445-4505	Greenlane	
1807	HJH720	2014	Hyundai Accent	410-4227	Greenlane	
1820	HLM80	2014	Mercedes Benz Sprinter	420-4246	Greenlane	
1800	JGR998	2014	Holden Cruze S/W	445-4643	Morningside	

1767	KDC795	2013	Hyundai Imax 8 seat	445-4634	Manawanui	
6800	TB7719	1994	LEYLAND LDV400	23133C	Rehab Plus	
1345	WT3227	1998	Mitsubishi Fuso	450-8200	Auckland Hospital	28/04/2015
1813	YR2018	1999	Toyota Corolla S/W	450-8243	Middlemore	16/04/2015
1812	YR5621	1999	Toyota Corolla S/W	450-8243	Waitakere	16/04/2015
9217	ZB1421	2000	Ford Transit	420-4246	Greenlane	13/01/2014

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Question 26 – Appendix 1

Vehicles purchased by Cost Centre

Cost Centre	Vehicle Model	Total amount spent per FY				
		13/14	14/15	15/16	16/17	17/18
03-410-3044	Hyundai Accent	\$18,688.00				
03-410-3082	Toyota Prius C Hybrid					\$21,605.00
03-410-4220	Hyundai I20 5DHB		\$16,680.07			
03-410-4222	Holden Cruze 1.8L S/W	\$22,397.94				
03-410-4223	Ford Custom Transit					\$55,664.06
03-410-4223	Holden Cruze 1.8L S/W	\$179,183.52				
03-410-4223	Hyundai I20 5DHB		\$16,680.07			
03-410-4223	Toyota Prius C Hybrid					\$21,558.72
03-410-4226	Hyundai Accent 5DHB	\$19,682.00				
03-410-4227	Holden Barina 5DHB		\$33,432.20			
03-410-4227	Hyundai Accent	\$37,376.00				
03-410-4227	Hyundai I20	\$16,464.40	\$34,376.00			
03-410-4227	Hyundai I20 5DHB Auto			\$31,548.00		
03-410-4227	Hyundai I20 5DHB		\$16,680.07	\$15,774.00		
03-410-4227	Hyundai I20 Med GL		\$16,680.07			
03-420-4233	Holden Cruze 1.8L S/W	\$22,397.94				
03-420-4237	Holden Barina 5DHB		\$16,716.10			
03-420-4241	Toyota Prius C Hybrid					\$21,289.00
03-420-4246	Holden Barina 5DHB		\$16,716.10			
03-420-4246	Holden Cruze 1.8L S/W	\$44,795.95				
03-420-4246	Holden Cruze 1.8L SW		\$23,212.37			
03-420-4246	Holden Cruze SW			\$20,511.12		
03-420-4246	Hyundai I20		\$34,376.00			
03-420-4246	Hyundai I20 5DHB		\$50,035.09	\$63,096.00		
03-420-4246	Mobile Ear Clinic	\$163,129.00				
03-430-5631	Holden Cruze 1.8L SW		\$23,212.37			
03-430-5631	Toyota Hiace 3.0TD		\$34,599.43			
03-430-6001	Hyundai I20 5DHB			\$15,774.00		
03-445-2028	Holden Cruze SW 1.8L			\$23,087.83		
03-445-2029	Holden Cruze 1.8L SW		\$23,212.37			
03-445-2030	Toyota Hi Ace Minivan					\$43,451.05
03-445-2030	Toyota Prius C Hybrid					\$43,117.44
03-445-4505	Hyundai Accent	\$18,688.00				
03-445-4505	Hyundai I20 5DHB			\$31,547.86		
03-445-4625	Hyundai Accent 5DHB		\$19,440.87			
03-445-4625	Hyundai I20 5DHB		\$16,680.07			
03-445-4626	Hyundai I20		\$19,441.00			
03-445-4626	Hyundai I20 5DHB			\$15,773.93		

03-445-4626	Hyundai i20 5DHB		\$33,360.14		
03-445-4627	Holden Barina 5DHB			\$16,600.25	
03-445-4627	Holden Barina 1.6L				\$15,508.26
03-445-4627	Holden Cruze 1.8L S/W	\$44,795.88			
03-445-4627	Holden Cruze 1.8L SW		\$23,212.37		
03-445-4627	Hyundai Accent 5DHB	\$19,681.94		\$19,440.87	
03-445-4627	Hyundai Accent 5DHB				
03-445-4627	Hyundai i20 5DHB			\$15,773.93	
03-445-4627	Hyundai i20 5DHB		\$33,360.14		
03-445-4633	Holden Cruze 1.8L S/W	\$22,397.94		\$23,212.37	
03-445-4633	Holden Cruze 1.8L SW				
03-445-4633	Hyundai Accent	\$18,688.00			
03-445-4633	Hyundai i20 5DHB Auto			\$15,773.93	
03-445-4633	Toyota Prius C Hybrid				\$21,558.72
03-445-4634	Hyundai Accent 5DHB			\$19,325.02	
03-445-4635	Holden Barina 5DHB			\$33,200.50	
03-445-4635	Holden Cruze 1.8L SW		\$23,212.37		
03-445-4635	Hyundai Accent		\$19,441.00		
03-445-4635	Hyundai Accent 5DHB		\$19,440.87		
03-445-4635	Hyundai i20		\$17,188.00		
03-445-4635	Hyundai i20 5DHB Auto		\$33,360.14		
03-445-4637	Holden Barina 5DHB				\$15,532.83
03-445-4639	Holden Cruze 1.8 LS/W			\$41,034.00	
03-445-4639	Holden Cruze 1.8L S/W	\$44,795.88			
03-445-4639	Hyundai Accent 5DHB		\$19,440.87		
03-445-4643	Hyundai i20		\$34,376.00		
03-445-4643	Toyota Prius C Hybrid				\$21,605.00
03-445-4647	Toyota Prius C Hybrid				\$21,558.72
03-455-8514	Holden Cruze 1.8 LS/W			\$41,034.00	
03-455-8514	Hyundai i20 5DHB Auto			\$31,548.00	
03-455-8514	Hyundai i20 5DHB Auto			\$126,192.00	
Total by FY		\$693,162.39	\$711,215.39	\$557,594.37	\$31,041.09
					\$271,407.71

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Question 28 – Appendix 1

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Email and Internet Usage

Unique Identifier	PP01/SUP/005 – v03.00 - updated
Document Type	Policy
Risk Level	High - may result in significant harm to the patient/DHB
Function	Administration, Management and Governance
User Group(s)	ADHB only
• Organisation(s)	Auckland District Health Board (ADHB)
• Directorate(s)	Organisation wide
• Department(s)	All departments
• Used for which patients?	n/a
• Used by which staff?	All staff
• Excluded	n/a
Keywords	Acceptable, internet, email, confidentiality, access, prohibited
Author	Chief of Intelligence & Informatics
Authorisation	
• Owner	Chief of Intelligence & Informatics
• Delegate / Issuer	n/a
Edited by	Document Controller
First issued	February 2003
This version issued	08 September 2017 - updated
Review frequency	3 yearly
Document History	Combines both: • PP01/SUP/005 – Electronic Mail • PP01/SUP/009 – Internet Usage – now withdrawn

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1. Purpose of policy

Auckland District Health Board (ADHB) must ensure the increasing use of information technology maintains confidentiality, is not misused and is also secure and accurate. This policy provides guidance on the secure management and acceptable use of email and the Internet.

This policy is required to:

- Protect the reputation of ADHB
- Protect the integrity and security of ADHB's internal IT systems and applications (including patient and clinical Information)
- Ensure the internet and email services are used primarily for business purposes
- Ensure that emails are stored within the clinical or corporate record in accordance with the Public Records Act 2005 or Health Information Privacy Code 1994
- Ensure the internet and email services are utilised in a cost effective manner

2. Scope

The policy encompasses and applies to the following components:

- The use of email, both internal and external to ADHB, and related technologies such as internet newsgroups, web or internet based email or other email services
- The use of the internet for the retrieval of information utilising the web browsing software as provided (i.e. Microsoft Internet Explorer, Mozilla Firefox, Safari, Google Chrome, Citrix Secure Web)
- The use of email and / or internet services accessed via a mobile device, including but not limited to, Blackberry, Palm Pilot, tablet or mobile phone.

This policy applies to all:

- All ADHB employees (including permanent and temporary), contract staff, students, volunteers, and other users who utilise email or internet as provided by ADHB
- All resources and devices supplied by ADHB including laptops, mobile phones, internet accounts and modems when used from external locations, such as from home

3. Responsibilities

All staff to whom this policy applies, are required to:

- Be aware of the acceptable use and relevant legislation associated with the use of email and Internet systems. If in any doubt, they should seek clarification from their Line Manager.
- To use ADHB email and Internet access in an efficient, effective, ethical and lawful manner
- Undertake appropriate training in the use of email or the Internet

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4. Exceptions

ADHB recognises that periodically there will be a legitimate business requirement that does not comply with existing ADHB policy.

- Where this occurs, a request must be submitted to hA IS via the normal mechanisms (IS Service Desk), however this will require General Manager or Senior Management approval and in some cases CIO or CEO approval.
- These requests will be assessed and responded to on an exception basis.

5. Definitions

Term	Definition
Email	A message created using Microsoft Outlook, Outlook Web Access (Web Based Mail) or Citrix Secure Mail containing a communication of any length and transmitted over the Auckland DHB computer network to one or more addressees
Internet	General connection to the internet as well as access to and use of any internet based features, applications, functionality and services

6. Prohibited Activities

Internet and email is provided for purposes relating to ADHB business including associated research or business related educational activities. Non-business use of the internet and email is subject to all of the conditions detailed within this policy and should be kept to a minimum.

Reasonable non-business use of the internet is deemed to not exceed 30 minutes per day during lunch breaks. Web browsing using company assets before and after work should be limited to internet banking, non-business emails, news sites and directories (e.g. White Pages).

In addition to this Internet and Email Use Policy, the following activities are prohibited at ALL times and apply to ALL users:

- Users may not use the internet or email facilities to knowingly disable or overload any computer system or network, or to circumvent any system intended to protect the privacy or security of a patient or another user or system.
- Users may not use the internet or email facilities to knowingly download or distribute pirated software or information.
- Users may not use the internet or email facilities to participate in any form of internet socialising such as dating or chatting. This includes (but is not limited to) such sites as FB Messenger, Bebo, MySpace, Adultfinder, and NZ Dating.
- Users may not use the internet or email facilities to knowingly propagate any malicious software e.g. Virus, worm, Trojan horse, hacker tools or trap-door program code, or to obtain information or software intended or designed, disable, overload any computer system or network, or to circumvent any system intended to protect the privacy or security of a patient, another user, or system.
- Users may not use the internet or email facilities to download entertainment software or games, or to play or participate in games against opponents over the Internet or via email.
- Users may not use the internet or email facilities to participate in any form of gambling.
- Users may not undertake any activity that will contravene the laws of New Zealand.
- Users may not undertake any activity that infringes copyright, including (but not limited to) copying electronic files without permission or breaching the terms of any licence.

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- Users may not use the internet or email facilities for non-ADHB business, without prior written authorisation from the CEO or other delegated authority.
- Users may not use the internet or email facilities to transmit receive, distribute, view or download offensive, obscene, insulting, harassing, sexist, pornographic or otherwise inappropriate or offensive messages or pictures.
- User may not access live radio stations for personal use that are not work related
- Attempt to forge email messages or disguise your identity when sending emails.

7. Acceptable use of email and Internet

- The primary use of email and Internet must be related to ADHB business or authorised purposes
- Communication and collaboration with educators, students and researchers involved in education or research
- Communication for clinical care, professional development, to maintain currency, or to debate issues in a field or sub-field of knowledge
- Administrative or operational communications or activities in direct support of research and education

8. Use of email

Email is one of the main sources used by would-be attackers to gain unauthorised access to information and systems. As such, various security precautions must be implemented to secure corporate, employee and personal health information.

Access to the ADHB email system is provided to support business and administrative activities. Users need to be aware of the following:

- All messages generated on the ADHB email system are the property of ADHB
- Only the ADHB email system should be used for ADHB business communications when conducting ADHB business. Staff must not use personal (such as Gmail, Yahoo, Xtra) or other non ADHB email accounts to send or receive emails pertaining to ADHB business.
- All emails must contain an email signature that conforms to the ADHB guidelines
- As email is a common form of communication within and outside of ADHB it is essential that users check their mailbox on a regular basis and act accordingly
- Emails are ADHB preferred method of global communication. Rules must not be applied to automatically delete global emails.
- Email carries the same legal status as other written documents and should be used with the same care
- Emails used for business communication must be managed and retained in accordance with the Clinical Record Management and Corporate Information Management policies

8.1 Security and Confidentiality

healthAlliance (on behalf of ADHB) has installed security facilities to assure the safety and security of the networks. Any attempt to disable, defeat or circumvent these security facilities, including passwords and software licenses, may constitute serious misconduct.

Security and confidentiality of information cannot be guaranteed when using email.

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- Emails sent between hA, Auckland DHB, CMDHB and WDHB (including all hospitals & remote clinics), travel over a secure private link rather than the public internet.
- Emails sent to other locations will travel over the public internet potentially allowing them to be intercepted and read by individuals other than the intended recipients.
- Secure transmission has been enforced with some external agencies. Refer to up-to-date information available [here](#).

For this reason, it is recommended that commercially or clinically sensitive information is only sent via the secure links as outlined above.

If this is not possible, the information must be password protected. Refer to password protecting instructions available [here](#).

Sending commercially sensitive or clinically sensitive information to personal email accounts, such as gmail, Hotmail, yahoo, xtra, without password protection or encryption, is not permitted.

The IS Service Desk can provide further assistance and information on password protecting documents.

8.2 Personal use

Occasional personal use including accessing external email accounts such as Hotmail , Yahoo or Xtra is permitted, provided such use is not excessive or inappropriate and does not result in expense or harm to ADHB or otherwise violate this policy.

ADHB reserves the right to monitor email usage where it believes that there is a genuine cause for concern.

The excessive use of email through the ADHB email system by an individual for non-business purposes may result in that individual facing disciplinary measures and/or having their email account removed.

Factors relevant in determining whether usage is excessive include:

- The number of emails
- Their size (including attachments)
- Whether usage impacts upon staff carrying out their functions
- The amount of ADHB resource expended

8.3 Illegal content

ADHB has a zero tolerance policy for emails containing illegal content. Illegal content in an email by an individual may result in that individual facing disciplinary measures and/or having their email account removed.

The following are examples of but not limited to illegal content (which includes storage, sending or forwarding of emails):

- Pornographic images

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- Sexually explicit material, which could cause offense or distress to the recipient
- Any other content which is sent with deliberate intent to insult/offend/cause distress to the recipient

8.4 Auto forwarding of emails

ADHB does not permit the auto forwarding of email to any external mail service (Google, Yahoo, Xtra etc.) because of the risk of confidential information being unwittingly forwarded to an unsecure network.

8.5 Confidentiality statement

All emails sent to recipients outside of ADHB must include the approved Confidentiality Statement and Disclaimer.

The information contained in this email and any attachments is confidential and intended for the named recipients only. If you are not the intended recipient, please delete this email and notify the sender immediately. Auckland DHB accepts no responsibility for changes made to this email or to any attachments after it has been sent.

8.6 Global email

The use of an email to all recipients on the global address book is limited for distribution by the following:

- Chief Executive
- Chief of Intelligence & Informatics
- Director of Communication
- Incident Management Controller

8.7 Email correspondence with a patient

Whilst there may be benefits to both patients and ADHB from the use of emails , this is not a secure method of communication. Staff must always ensure that the patient is aware of the risks associated with communicating in this way and that this has been agreed and documented as part of the patient record.

Where a number of emails are exchanged regarding one matter, and it would be more appropriate for a summary of the email to be recorded and kept, then the health care professional involved must write or dictate a summary. Such summaries should contain the dates the emails span, the number of emails exchanged, who the emails were between, the subject matter, the conclusions reached and advice offered, plus any other relevant information. Summaries must be written frequently so that they are as contemporaneous as possible to the time of the communication. At a minimum, summaries must be written on a weekly basis.

Users should be careful about using this method of communication when information provided by the patient indicates a face-to-face intervention or clinical assessment is needed.

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Any information relevant to the patient's ongoing care must be captured in the patient record. Copies of email correspondence to be printed out in full or attached to the patient's electronic record.

9. Using the Internet

ADHB's link to the Internet is intended to support clinical, learning and research activities by ADHB staff. In general, Internet access is a Business tool.

9.1 Personal use

ADHB Management recognizes that staff with access to the Internet from the ADHB network will use the resource for private use.

While incidental use is acceptable, excessive use of the resource under the guidelines of Unacceptable use could be treated as a disciplinary matter.

9.2 Internet access required through ADHB network

All desktop personal computers laptops requiring access to the Internet must go through the ADHB Computer network, which has Proxy and Firewall technology. This is to protect the ADHB computer network and information contained within it.

9.3 Secure file transfers

The Internet and sites on the Internet must not be used for any business-related file transfers unless files/information has been appropriately encrypted and password protected.

9.4 Monitoring Internet access

ADHB provides Internet access for conducting business. No user should have the expectation of privacy when using the ADHB network to browse the internet. All Internet access will be recorded and regularly monitored to ensure the system is being used effectively and in line with this policy and all relevant legislation.

Information Management Services reserves the right to:

- suspend services when necessary to maintain the network.
- advise any user, or user's Line Manager, of high traffic usage or usage that may contravene the use guidelines within this policy

Apparent or alleged violations of these guidelines will be investigated and documented by Information Management Services. You are expected to co-operate with investigations by Information Management Services staff both with technical problems or possible unauthorised or irresponsible use as defined in these guidelines. Cases of apparent abuse will be referred to the appropriate Line Manager responsible for any further investigation and may be subject to ADHB's disciplinary procedures.

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10. Legislation

- Copyright Act 1994
- Electronic Transactions Act 2002
- Evidence Act 2006
- Films, Videos, and Publications Classification Act 1993
- Health Information Privacy Code 1994
- Official Information Act 1982
- Privacy Act 1993
- Public Records Act 2005
- Unsolicited Electronic Messages Act 2007

11. Associated Auckland DHB documents

- Clinical Records Management Policy
- Information and Security Policy
- Mobile Devices Policy
- Social Media Policy

12. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed **before** the scheduled date, they should contact the owner or [Document Control](#) without delay.

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Question 30 – Appendix 1

Name of Project	Total Project Budget	Start Date	Completion Date	Total Cost at Completion
ADHB Managed Projects				
IGS0211 Rostering RiTA	\$2,400,000	Nov-11	Jun-19	\$2,400,000
CSSD Instrument Tracking	\$1,317,742	May-15	Dec-18	\$752,373
EDS Optimisation	\$98,150	May-15	Feb-18	\$8,060
Tracking System Pathology	\$562,772	Oct-14	Feb-19	\$350,000
Trendcare Rollout	\$842,890	Oct-14	Jun-19	\$842,890
Ophthalmology Patient Flow Imp	\$416,350	Jul-15	Feb-19	\$416,350
eMedicines Reconciliation	\$450,773	Jul-15	Dec-18	\$370,000
Metric Automation Dashboard P2	\$99,540	Jul-15	Feb-18	\$97,098
ePrescribing Early Adopter	\$1,917,757	Jun-15	Feb-18	\$1,824,049
Winscribe Voice Recognition	\$424,938	Oct-15	Feb-18	\$424,938
Video Audio File storage system	\$98,640	Mar-16	Jun-18	\$40,743
Implementation of eReferrals	\$79,800	Mar-16	Jun-19	\$79,800
CCMS Implementation continued	\$85,000	Apr-16	Jun-19	\$85,000
Contract Volume Cube & Reports	\$96,680	Jun-16	Feb-18	\$96,680
Thrombosis database	\$72,975	Jul-16	Feb-18	\$46,717
Growth Chart-chart publishing	\$91,062	Jun-12	Dec-18	\$47,701
Genetics Clinical Database	\$157,909	Jun-13	Feb-18	\$154,347
Pager Replacement Requirements	\$54,000	Sep-15	Jun-18	\$53,000
Leave Manager planning study	\$40,000	Oct-15	Jun-18	\$40,000
BI Costing Feeder Files	\$89,440	Nov-15	Oct-17	\$89,440
BI Atlas to Titan Reporting	\$89,720	Nov-15	Oct-17	\$89,720
Hepatocellular carcinoma dbase	\$62,800	Mar-16	Feb-19	\$62,800
PlanView Implementation	\$62,750	Mar-16	Feb-18	\$40,830
Delphic Core Upgrade	\$353,886	Dec-15	Mar-18	\$353,886
Rosella Programme VR Project	\$50,000	Dec-16	Dec-17	\$50,000
Business Objects 4.2 Upgrade	\$1,845,776	Jan-17	Feb-19	\$1,845,776
ADHB Leader Upgrade	\$255,852	Dec-16	Dec-19	\$255,852
ePA Implementation Marion & Ra	\$184,409	Dec-16	May-18	\$129,134
ILD Clinical Database	\$90,300	Feb-17	Feb-18	\$17,776
Infectious Diseases OPIVA D	\$77,850	Feb-17	Feb-18	\$56,936
Multiple Sclerosis Database	\$71,250	May-17	Feb-18	\$26,596
Intrathecal Analgesia Database	\$50,750	Jun-17	Feb-18	\$46,717
Deep Brain Simulation Database	\$48,300	Jun-17	Jun-18	\$26,521
CMS Enhancement Analysis 17/18	\$97,760	Jun-17	Oct-18	\$97,705
PHIMS software platform upgrade	\$496,555	Dec-16	Jun-18	\$496,555
ACC Elective Surgery Database	\$160,050	Jun-17	Dec-18	\$160,050
Renal Database	\$25,624	Jan-17	Jun-18	\$25,624
ANZICS APD data base upgrade	\$8,905	Apr-17	Dec-17	\$8,905
CVICU Database Upgrade	\$16,954	May-17	Jun-18	\$16,954

Deteriorating Patients Phase 1	\$48,300	Oct-16	Jun-18	\$48,193
eReferrals Inter & Intra DHB	\$45,360	Apr-17	Jun-19	\$45,360
Virtual Reality Implementation	\$89,892	Apr-17	Dec-18	\$89,892
National Patient Flow Phase 3	\$195,000	May-16	May-18	\$138,575
CMS Enhancement Analysis	\$120,000	Jul-14	Nov-17	\$119,990
MPS Platforms	\$294,000	Jun-17	Jun-19	\$294,000
ARPHS Informatics Workplan	\$496,555	Jun-17	May-18	\$485,169
ACC Elective Surgery Database	\$160,050	Jun-17	Dec-18	\$155,821
ORL MDM Room	\$64,514	Jun-18	Feb-19	\$64,514
Adaptive IT System Fert. Plus	\$52,934	Oct-17	Feb-19	\$52,934
APS Specimen Tracking	\$815,005	Jun-18	Jun-19	\$815,005
Agfa Xero Image Capture POC	\$17,520	Oct-17	Jun-18	\$0
ICNet Integration Change	\$7,500	Jan-18	Oct-18	\$7,460
Visibility of Pathways Concerto	\$20,900	Feb-18	Dec-18	\$12,000
SMT Upgrade eMedicine Recon	\$29,000	Feb-18	Mar-19	\$29,000
Sleep Database Enhancements	\$12,700	Mar-18	Oct-18	\$12,675
CMS Operating System Database	\$50,089	Mar-18	Jul-19	\$50,089
Patching for AIDA Devices	\$10,000	Apr-18	Oct-18	\$10,000
PIMs Theatre Operating System	\$43,000	Apr-18	Aug-19	\$43,000
NICU pathway	\$62,172	Apr-18	Jun-19	\$62,172
Paed Endocrinology Database	\$37,125	Apr-18	Mar-19	\$37,125
Bariatric Pathway Database	\$38,775	Apr-18	Apr-19	\$38,775
DCCM Database ANZICS Enhance	\$17,737	Jun-18	May-19	\$17,737
Patient Email & Mobile No Vali	\$181,004	Aug-17	Feb-19	\$181,004
MUSE Replacement	\$329,301	Aug-17	May-19	\$329,301
Ward Consultation Database	\$49,050	Sep-17	Jan-19	\$49,050
PICU Clinical Database	\$74,090	Sep-17	Feb-19	\$74,090
Mental Health CVD Screening	\$70,700	Oct-17	Jun-19	\$70,700
HCC Concerto Integration	\$210,800	Oct-17	Mar-19	\$210,800
IS Stabilisation Phase 1	\$480,000	Oct-17	Oct-18	\$480,000
3M Clinical Record System Upgr	\$1,284,596	Oct-17	May-19	\$985,000
Daily Hospital Functioning	\$438,700	Nov-17	Mar-19	\$438,700
MFM View Point Upgrade	\$315,933	Nov-17	May-19	\$315,933
Soprano Medical Docume Upgrade	\$496,108	Nov-17	Mar-19	\$496,108
HIV Database Enhancements	\$32,625	Nov-17	Feb-19	\$32,625
ImageNet Upgrade	\$464,038	Dec-17	Jan-19	\$464,038
Healthware Upgrade	\$495,600	Dec-17	Feb-19	\$495,600
Need to Approval System	\$343,800	Mar-18	Feb-19	\$343,800
Mental Health Data Mart	\$165,000	Mar-18	Jun-19	\$165,000
Enterprise Asset Management	\$955,481	Mar-18	Jun-19	\$1,200,000
Otago Clinical Audit Upgrade	\$93,500	Apr-18	Jun-19	\$93,500
IS Stabilisation Phase 2	\$280,000	May-18	Feb-19	\$280,000
Titan Data Warehouse Phase II	\$397,760	Jun-18	Jun-19	\$397,760
CMS Enhancement Analysis 1819	\$96,800	Jun-18	Sep-19	\$96,800
Perioperative Pathway Database	\$59,190	Jun-18	Mar-19	\$59,190
Stabilisation Phase 2 Remediat	\$42,000	Jun-18	Feb-19	\$42,000

healthAlliance Managed Projects - ADHB				
	\$		\$	\$
ADHB & NDHB Clinical Portal Upgrade (5269)	435,595	28/03/2017	01/02/2020	324,688
ADHB 2 Degrees In-Building Solution for Auckland City Hospital (4973)	\$ 9,557	01/03/2017	27/07/2018	\$ 8,223
ADHB ACH Blood Bank Expansion (4319)	\$ 9,684	01/01/2018	30/06/2018	\$ 9,684
ADHB ARPHS Discharge Letters to GP's (3900)	\$ 9,300	02/02/2017	30/09/2017	\$ 9,300
ADHB ARPHS Liquor and Alcohol CRM module (4577)	200,296	05/01/2016	03/03/2018	\$ 199,589
ADHB ARPHS SharePoint Migration (4866)	\$ 94,933	01/11/2016	24/05/2018	\$ 88,486
ADHB ARPHS Surveillance Virtual Server (5395)	17,000	09/05/2018	29/08/2025	\$ 16,986
ADHB Arrival Status on Concerto Outpatient Search List (5343)	\$ 23,000	19/03/2018	01/09/2018	\$ 11,460
ADHB Automated Medication system after hours/ Emergency Medicine cupboard (4426)	\$ 123,000	01/08/2016	24/11/2018	\$ 123,000
ADHB Building Infrastructure Upgrade (5114)	\$ 985	18/07/2017	01/08/2018	\$ 985
ADHB Chemwatch Gold FFX (5479)	\$ 8,000	11/06/2018	03/08/2018	\$ 2,575
ADHB Clinical Correspondence (4744)	\$ 76,724	19/09/2016	30/08/2018	\$ 85,547
ADHB Clinical Portal Upgrade – DHB Resource (5374)	120,000	07/04/2018	01/10/2019	\$ 120,000
ADHB Clinical Studies (ACS) on Citrix (5334)	\$ 14,000	27/02/2018	30/08/2018	\$ 8,740
ADHB CMS 38 (4420)	240,000	21/09/2015	06/10/2017	\$ 238,764
ADHB CMS 39 (4423)	\$ 324,983	09/01/2017	27/06/2018	\$ 324,514
ADHB CMS 40 (5265)	\$ 339,772	30/11/2017	01/03/2019	\$ 339,782
ADHB Community Mental Health 95 GT Sth Road (5004)	44,067	11/04/2017	01/08/2018	\$ 40,105
ADHB CRAT for POC of Pivot Software for HR (5089)	\$ 6,240	01/07/2017	21/12/2017	\$ 5,111
ADHB Create Production and Acceptance Environment for Chas3 Software (4369)	\$ 74,724	28/09/2015	04/08/2017	\$ 74,050
ADHB CVICU ANZICS Database Upgrade (5031)	\$ 7,000	02/09/2017	01/10/2018	\$ 910
ADHB Datafactory Connectivity to Azure (5370)	223,120	29/03/2018	31/12/2018	\$ 20,160
ADHB Datix Software Solution to Replace Risk Monitor and Feedback Monitor Pro (4288)	\$ 337,495	22/03/2016	14/02/2018	\$ 280,418
ADHB Delay GP Discharge Summaries (5387)	\$ 52,000	11/06/2018	01/10/2018	\$ 52,000

	\$		\$	
ADHB Eclair Interface for Modality Reports (5398)	32,000	11/06/2018	01/10/2018	32,000
ADHB Enabling NZBS Histotrac information to be sent to éclair (5368)	\$ 7,000	17/04/2018	29/09/2018	\$ 6,873
ADHB Epicentre Application Setup (4724)	\$ 15,000	31/10/2016	07/10/2018	\$ 30,570
ADHB Genetics FISH Analysis Automation (5386)	\$ 11,000	11/06/2018	01/10/2018	\$ 11,000
ADHB Grafton AED (CDU) Expansion & Redevelopment (4318)	\$ 140,304	01/12/2015	01/09/2018	\$ 140,304
ADHB Greenlane AMD Migration (5096)	\$ 234,000	04/08/2017	12/06/2018	\$ 232,798
ADHB Greenlane Power Work G11 G12 G13 Dec 17 (5303)	\$ 9,520	02/12/2017	07/02/2018	\$ 3,060
ADHB Haemodynamic Monitoring System (4680)	\$ 425,651	03/10/2016	04/07/2018	\$ 289,127
ADHB IMPAX Tape Migration (2528)	\$ 72,085	02/12/2011	11/08/2017	\$ 69,680
ADHB Implement Orion National Medical Warning Module in Concerto (4968)	\$ 23,000	14/03/2017	21/03/2018	\$ 21,123
ADHB Implementation of Kronos Clocks Module (4668)	\$ 22,397	26/07/2016	15/12/2017	\$ 22,397
ADHB Infection Prevention and Control System (ICNET) (3852)	\$ 499,964	24/02/2015	29/06/2018	\$ 499,947
ADHB Innoforce System for ORL (5288)	\$ 7,200	02/12/2017	28/02/2018	\$ 4,770
ADHB Linear Accelerator Replacement (4529)	\$ 533,843	09/01/2017	27/04/2018	\$ 389,072
ADHB Mediota SaaS Solution Womens Health (5018)	\$ 9,000	23/05/2017	04/10/2017	\$ 3,788
ADHB Metro PACS Upgrade (4405)	\$ 855,103	27/11/2014	28/07/2018	\$ 852,668
ADHB Migrate Elfin to a Server (4910)	\$ 8,362	22/05/2017	01/09/2018	\$ 8,346
ADHB MOH file format changes to death notifications (4890)	\$ 20,000	02/06/2017	08/01/2018	\$ 20,095
ADHB New Substation Building next to Labplus Building (4875)	\$ 56,643	23/11/2016	01/11/2018	\$ 56,643
ADHB Patient Clinical Record POC CRAT (5529)	\$ 400	22/06/2018	16/07/2018	\$ 429
ADHB PCMS Network (5358)	\$ 9,106	22/12/2017	01/01/2019	\$ 9,106
ADHB PJM RFID Implementation Support (4790)	\$ 14,000	16/01/2017	22/01/2018	\$ 12,573
ADHB Plethysmograph Replacement (5213)	\$ 10,990	01/11/2017	19/05/2018	\$ 10,990
ADHB PRIMHD Application Development (5027)	\$ 11,000	01/09/2017	01/12/2018	\$ 11,010
ADHB Prosolv application Upgrade (3421)	\$ 185,736	20/08/2013	27/09/2017	\$ 222,884

ADHB Publishing of Documents to electronic repositories (4419)	\$ 84,996	12/10/2015	25/05/2018	\$ 79,264
ADHB Rauland Nurse Call – Stage 1 (4934)	\$ 112,068	10/12/2016	31/10/2017	\$ 60,096
ADHB RayStation New Citrix Server (5165)	\$ 28,555	16/01/2018	01/10/2018	\$ 24,432
ADHB Relocation of staff to Pounamu Ward on the Rehab Plus site (5014)	\$ 2,570	16/05/2017	02/08/2017	\$ 2,570
ADHB Replacement of Cardiopulmonary Exercise System (4579)	\$ 43,798	10/08/2016	01/07/2018	\$ 600
ADHB Retinal Screening OptoMize Software (4988)	\$ 6,720	19/04/2017	31/12/2018	\$ 5,398
ADHB Robotic Process Automation (RPA) Pilot (5400)	\$ 36,000	01/06/2018	29/09/2018	\$ 23,245
ADHB ROERS Eclair Auto sign duplicate radiology reports (3747)	\$ 16,532	19/09/2016	29/12/2017	\$ 1,018
ADHB SaaS Business Continuity System (5159)	\$ 6,250	10/10/2017	28/02/2018	\$ 5,129
ADHB Scope for Blood Science Work Area (4855)	\$ 159,950	08/11/2016	30/06/2018	\$ 143,599
ADHB Security Hub Room Project (5510)	\$ -	05/07/2018	01/07/2019	\$ 40,000
ADHB Security Upgrade – Hub Rooms (4391)	\$ 832,000	02/08/2015	21/06/2018	\$ 776,640
ADHB Security Upgrade – Servers and Storage (4392)	\$ 900,000	01/07/2015	15/03/2018	\$ 634,575
ADHB Security Upgrade Project (4270)	\$ 7,600	04/05/2015	01/08/2019	\$ 400
ADHB Server for DNA Analysis (5402)	\$ 17,000	04/06/2018	13/10/2018	\$ 16,991
ADHB Starship Fibre Resilience (4895)	\$ 114,548	12/12/2016	26/10/2017	\$ 114,432
ADHB Starship Level 5 Redevelopment (4545)	\$ 183,786	16/02/2016	18/04/2018	\$ 240,877
ADHB TCIWorks Drug Dosing Tool software Replacement (3937)	\$ 260	13/10/2014	21/11/2017	\$ 325
ADHB Tier 1 Hub Room Upgrade (5081)	\$ 455,000	03/07/2017	27/07/2018	\$ 435,082
ADHB Titanium V 52 to V 76 Upgrade (4463)	\$ 532,250	16/10/2015	12/07/2017	\$ 531,801
ADHB TopCat Cleaning Management System (4828)	\$ 42,552	02/10/2016	22/12/2017	\$ 34,921
ADHB Upgrade Cardionavigator Plus (4276)	\$ 168,150	18/05/2016	18/08/2018	\$ 168,995
ADHB Upgrade CMS to RIS Interface to Reduce Radiology Study Patient DNAs (4374)	\$ 14,420	26/09/2016	04/12/2017	\$ 14,418
ADHB Upgrade HCC Community Sexual Health(4299)	\$ 441,718	19/01/2015	28/02/2018	\$ 436,427
ADHB Upgrade HCC Diabetes (4407)	\$ 417,322	03/08/2015	29/06/2018	\$ 409,294
ADHB Upgrading Xray Equipment on GBI (5327)	\$ 10,000	09/02/2018	18/07/2018	\$ 6,230

ADHB Vigilant ASE-NET Fire Systems Management System (4827)	\$ 5,000	23/03/2017	08/11/2017	\$ 4,055
ADHB WDHB Contact Centre Solution Fault Remediation (5099)	\$ 370,000	18/07/2017	08/06/2018	\$ 368,799
ADHB WDHB Contact Centre Upgrades FY18/19 (5384)	\$ 255,000	24/04/2018	01/12/2018	\$ 267,765
ADHB WDHB Rightfax Upgrade (2518)	\$ 293,089	29/03/2016	08/06/2018	\$ 287,494
ADHB West Auckland Sexual Health Clinic Move (5163)	\$ 26,230	31/07/2017	31/07/2018	\$ 18,874
ADHB WiFi Coverage Expansion (4955)	\$ 233,000	28/02/2017	15/12/2017	\$ 231,885
ADHB WiFi Coverage Expansion FY1718 (5074)	\$ 361,000	29/06/2017	01/10/2018	\$ 365,287
Metro and ADHB Leader Kiosk Upgrade (4854)	\$ 1,250,012	07/11/2016	28/09/2018	\$ 1,049,042

healthAlliance Managed Projects - Regional

19254 - Reg Enterprise Arch - Design Integration (5140)	\$ 230,000	02/08/2017	04/09/2017	\$ 230,000
Regional Server Patching (Cycle 1 & 2) (5467)	\$ 400,000	12/06/2018	01/01/2019	\$ 400,000
Regional AMS Leader Upgrade (4838)	\$ 14,454	06/10/2016	14/07/2017	\$ 5,420
Regional Backup Expansion (5097)	\$ 392,460	07/07/2017	21/07/2018	\$ 299,938
Regional Bitlocker Deployment (3956)	\$ 425,000	26/08/2014	25/08/2018	\$ 312,530
Regional C1C2 SQL 2014 Platform (4740)	\$ 499,577	09/08/2016	16/08/2017	\$ 494,943
Regional Capacity Management Plan (5149)	\$ 160,000	15/02/2018	30/09/2018	\$ 116,316
Regional Citrix Growth and Stability (4867)	\$ 497,594	04/10/2016	22/09/2017	\$ 469,819
Regional Cluster Remediation - CPU Licensing (5553)	\$ -	05/07/2018	01/10/2018	\$ 226,000
Regional Cluster Review (5177)	\$ 225,000	12/09/2017	01/09/2018	\$ 230,804
Regional Compute Capacity - Grafton (5366)	\$ 450,000	12/03/2018	30/06/2018	\$ 2,899,298
Regional Compute Capacity – Middlemore (5367)	\$ 450,000	12/03/2018	30/06/2018	\$ 300,225
Regional Compute Storage Refresh and Expansion (4492)	\$ 3,405,169	02/10/2015	17/07/2017	\$ 3,203,965
Regional Computer Room Remediation (4987)	\$ 473,000	11/04/2017	04/07/2018	\$ 497,505
Regional Computer Room Remediation 17/18 (5326)	\$ 264,340	02/02/2018	01/08/2018	\$ 240,264
Regional Core Firewall Refresh (4977)	\$ 155,139	04/04/2017	29/06/2018	\$ 143,963
Regional Cyber - Advanced Threat Management (5037)	\$ -	02/07/2017	01/11/2018	\$ -

	490,000			484,459
	\$			\$
Regional Cyber - Application Firewall FY1617 (4843)	72,000	04/10/2016	31/05/2018	64,718
	\$			\$
Regional Cyber - Awareness Platform (5021)	39,500	24/05/2017	26/06/2018	37,958
	\$			\$
Regional Cyber - GCIO Ext Web sites - Balance (5146)	220,000	31/08/2017	13/12/2018	201,769
	\$			\$
Regional Cyber - Incident Response (5142)	55,000	19/09/2017	22/06/2018	54,900
	\$			\$
Regional Cyber - Log Management (5059)	65,000	02/07/2017	31/05/2018	64,974
	\$			\$
Regional Cyber - Mobility Threat Management (5161)	400,000	28/08/2017	28/09/2018	399,392
	\$			\$
Regional Cyber - Network Inspection (5013)	395,000	03/06/2017	01/09/2018	389,437
	\$			\$
Regional Cyber - Password Vault FY1617 (4844)	90,000	03/10/2016	31/05/2018	89,948
Regional Cyber - Policy and Standard Development (5094)	\$			\$
	400,000	02/08/2017	29/06/2018	399,739
	\$			\$
Regional Cyber - Privileged Account Mgmt (5143)	200,000	02/11/2017	30/11/2018	200,000
	\$			\$
Regional Cyber - Securing OWA (4869)	330,000	19/11/2016	10/08/2018	329,432
	\$			\$
Regional Cyber - Security Governance (5093)	150,000	02/07/2017	29/06/2018	149,998
	\$			\$
Regional Cyber - Server Anti Malware (5024)	220,000	24/05/2017	25/06/2018	217,486
	\$			\$
Regional Cyber - ShareFile POC (5290)	60,000	02/12/2017	29/06/2018	59,998
	\$			\$
Regional Cyber – Virtual Patch Server Fleet (5019)	250,000	24/05/2017	03/07/2017	249,620
	\$			\$
Regional Cyber - Vulnerability Management (5127)	300,000	05/06/2017	01/11/2018	298,456
Regional Cyber Baseline Server Fleet Vulnerability (5050)	\$			\$
	375,000	03/07/2017	31/10/2017	374,991
	\$			\$
Regional Cyber Plan – Security Standards FY1617 (4845)	150,000	25/10/2016	25/10/2017	148,865
	\$			\$
Regional Cyber Server Patching Q3-4 FY1617 (4917)	250,000	17/01/2017	31/10/2017	248,141
	\$			\$
Regional Data Centre as a Service (DCaaS) - IBC (5068)	422,500	01/06/2017	01/12/2017	421,944
	\$			\$
Regional Desktop Power Savings Implementation (4965)	105,000	13/03/2017	04/10/2018	108,439
	\$			\$
Regional Desktop Replacement FY1617 (4781)	3,150,000	01/09/2016	28/07/2017	3,146,166
Regional Desktop Replacement FY1718 – 4th Stage (5282)	\$			\$
	449,000	02/12/2017	30/06/2018	549,350
Regional Desktop Replacement FY1718 - 5th Stage (5310)	\$			\$
	480,000	01/03/2018	30/06/2018	537,450
	\$			\$
Regional Dial Plan - CMH and ADHB (5078)	453,010	21/07/2017	01/06/2018	435,786
Regional Dialling Plan FY16/17 (4863)	\$	07/11/2016	05/02/2018	\$

	480,500			425,300
Regional Directory Remediation – Certificate Services (4941)	\$ 122,334	18/02/2017	28/09/2018	\$ 92,058
	\$			\$
Regional Directory Remediation SAH & WHL (4915)	209,000	23/01/2017	30/06/2018	196,905
	\$			\$
Regional Directory Services Remediation (4416)	492,472	14/09/2015	09/01/2018	496,107
	\$			\$
Regional Disk Backup Appliance - Grafton (4983)	399,952	27/03/2017	29/06/2018	399,193
	\$			\$
Regional DTaaS – Detail Transition Planning (5377)	463,980	01/05/2018	01/11/2018	479,000
Regional DTaaS – Detailed Design Planning/Mobilisation (5211)	\$ 364,840	02/10/2017	29/06/2018	\$ 498,999
	\$			\$
Regional DTaaS - TaaS RFP (5293)	499,914	01/01/2018	30/04/2018	498,100
	\$			\$
Regional DTaaS - TaaS Secondary Procurement (5335)	282,689	01/03/2018	01/07/2018	499,000
Regional DTaaS – Workload Assessment & Migration Evaluation (5376)	\$ 271,216	02/05/2018	30/06/2018	\$ 386,311
	\$			\$
Regional DTaaS Gateway Review and Governance sign off (5087)	\$ 460,491	01/08/2017	23/02/2018	\$ 421,740
	\$			\$
Regional EMM platform (4523)	2,385,000	22/12/2015	06/07/2017	2,385,000
	\$			\$
Regional Enhanced Print Device Management (4759)	150,000	09/08/2016	13/12/2017	21,281
Regional Exadata Migration and Decommissioning (5090)	\$ 300,000	03/07/2017	31/08/2018	\$ 309,086
	\$			\$
Regional Exadata Platform patching (5505)	\$ -	02/10/2018	01/07/2019	50,000
	\$			\$
Regional Exadata Upgrade – Grafton (4737)	497,573	02/03/2016	29/06/2018	482,612
	\$			\$
Regional Exadata Upgrade – Middlemore (4738)	410,135	02/03/2016	29/06/2018	412,699
	\$			\$
Regional Exadata Upgrade – MMH Dev (4554)	403,567	02/03/2016	29/06/2018	400,736
	\$			\$
Regional Exchange Platform Growth (4816)	50,000	14/09/2016	02/10/2017	49,923
	\$			\$
Regional Exchange Remediation (5076)	220,390	02/08/2017	16/12/2018	136,190
	\$			\$
Regional F5 Load Balancing EOL Replacement (4745)	43,968	02/08/2016	11/07/2017	32,611
Regional Facilities Monitoring and Alerting ADHB NDHB (5079)	\$ 250,000	15/07/2017	26/06/2018	\$ 243,748
	\$			\$
Regional Firewall Consolidation & Tuning 2016 (4793)	90,000	19/08/2016	24/08/2017	80,726
	\$			\$
Regional Grafton Tier2 Storage Growth (4908)	486,338	13/12/2016	30/11/2017	418,136
	\$			\$
Regional Healthsafe Deployment AWS (5375)	99,000	02/04/2018	25/05/2018	99,000
	\$			\$
Regional HealthSafe Digital Foundations (4979)	415,718	22/03/2017	30/06/2018	396,277
Regional HHS upgrade (5067)	\$	22/06/2017	12/02/2018	\$

	29,700			26,639
	\$			\$
Regional Hub Room Remediation FY1617 (4712)	301,924	04/07/2016	21/08/2017	301,924
	\$			\$
Regional Hub Room UPS Remediation (5283)	250,000	04/12/2017	21/07/2018	259,786
				\$
Regional Hub Room UPS Upgrades Schedule 1 (5486)	\$	-	01/06/2018	01/07/2019
				240,000
	\$			\$
Regional Hub Room UPS Upgrades Schedule 2 (5487)	\$	-	01/06/2018	01/07/2019
Regional Identity & Access Management Strategy (5030)	\$			\$
	502,676	12/06/2017	01/07/2018	504,583
Regional Identity and Access Management (IAM) Strategy (5312)	\$			\$
	499,000	03/10/2017	31/07/2018	318,700
	\$			\$
Regional Information Security Planning (4675)	158,000	07/06/2016	12/10/2017	156,736
Regional Integration Engine (IEP) Programme (ESB/JCAPS replacement) (4841)	\$			\$
	10,593,644	09/03/2017	29/03/2019	10,577,201
	\$			\$
Regional Internet Access Consolidation (4792)	211,476	12/07/2016	06/10/2018	216,734
	\$			\$
Regional Internet Optimisation (2627)	410,000	05/06/2013	31/01/2018	405,714
	\$			\$
Regional ISSP – BI and Analytics Strategy (5217)	320,401	01/02/2018	29/06/2018	320,400
Regional ISSP 2.0 Programme Management - Establish (5060)	\$			\$
	481,700	03/07/2017	23/05/2018	481,660
	\$			\$
Regional ISSP APM Implementation (5100)	318,000	02/02/2017	29/06/2018	318,000
	\$			\$
Regional ISSP APM Operationalisation (5154)	489,000	02/04/2018	01/11/2018	458,508
	\$			\$
Regional ISSP Applications Roadmap – Phase 1 (5155)	468,158	16/08/2017	23/05/2018	468,159
	\$			\$
Regional ISSP Applications Roadmap – Phase 2 (5287)	489,972	08/01/2018	30/06/2018	497,056
Regional ISSP Data Information Strategy & Architecture(5151)	\$			\$
	370,000	02/07/2017	29/06/2018	370,000
Regional ISSP Devices, Channel and Workspace Strategy (5153)	\$			\$
	351,000	02/07/2017	01/07/2018	314,480
	\$			\$
Regional ISSP EA Integration Design (5152)	140,000	08/06/2017	04/09/2017	140,000
	\$			\$
Regional ISSP EA Tools Implementation (5101)	293,111	04/07/2017	29/06/2018	293,001
	\$			\$
Regional ISSP Enterprise Architecture - Establish (5063)	494,300	03/07/2017	01/04/2018	494,300
	\$			\$
Regional ISSP Enterprise Architecture – Phase 2 (5307)	271,568	08/01/2018	01/07/2018	271,573
	\$			\$
Regional ISSP Health Safe Prototype (5164)	25,000	21/08/2017	15/09/2017	18,165
Regional ISSP Information Management Capability - Establish (5150)	\$			\$
	252,600	17/10/2017	05/07/2018	252,600
Regional ISSP Programme Management – Phase 2 (5304)	\$			\$
	415,339	08/01/2018	29/06/2018	456,382

	\$		\$
Regional ISSP Workspace Business Case (5135)	4,950,002	13/11/2017	01/07/2021
	\$		\$
Regional LAN Switch Replacement FY1617 (4751)	328,000	08/08/2016	19/07/2017
	\$		\$
Regional Legacy WAN services replacement (4926)	416,000	23/01/2017	30/06/2018
	\$		\$
Regional MAS Replacement Capacity Growth (5025)	480,601	01/06/2017	21/07/2017
	\$		\$
Regional MAS Risk Mitigation (4752)	225,000	10/08/2016	26/01/2018
	\$		\$
Regional Microsoft License Review (G2018) (5267)	205,000	07/11/2017	01/09/2018
	\$		\$
Regional Middlemore Tier2 Storage Growth (4907)	389,000	13/12/2016	30/11/2017
	\$		\$
Regional Minor Environmental Upgrades (5112)	150,000	24/07/2017	01/07/2018
	\$		\$
Regional Monitoring & Discovery FY1617 (4919)	456,000	31/01/2017	14/07/2018
	\$		\$
Regional Monitoring & Discovery Stage 2 (5513)	\$	-	02/07/2018
	\$		01/07/2019
Regional NCAMP 2017 (4963)	78,308	15/02/2017	18/04/2018
Regional Network Attached Storage (NAS) Solution (4799)	\$		\$
	485,218	25/08/2016	26/01/2018
Regional Network Grafton CORE card replacement (4953)	\$		\$
	379,577	05/05/2017	05/07/2018
Regional Network Hub Room Upgrades (ADHB) (5485)	\$		\$
	350,717	02/07/2018	01/07/2019
Regional Network Hub Room Upgrades (CMDHB) (5473)	\$		\$
	402,000	02/07/2018	29/06/2019
Regional Network Hub room upgrades (NDHB) (5474)	\$		\$
Regional One Network Phase 3 exit from Galbraith (4516)	499,400	02/07/2018	29/06/2019
	\$		\$
Regional Oracle EBS Platform Stabilisation (5404)	329,020	08/12/2015	27/11/2017
	\$		\$
Regional OSR WS2003 Mitigation (4612)	120,000	02/05/2018	01/04/2019
	\$		\$
Regional P2V Phase 4 (4957)	490,000	02/05/2016	09/01/2018
	\$		\$
Regional PABX Risk Mitigation - Regional Telephony Resiliency (5008)	365,000	24/02/2017	12/06/2018
	\$		\$
Regional Paging Service Replacement (4553)	421,730	06/06/2017	21/06/2018
	\$		\$
Regional Paging Transition - Tactical (5049)	402,000	01/03/2016	29/06/2018
	\$		\$
Regional SAN Volume Controller Remediation (5284)	294,000	20/05/2017	26/01/2018
	\$		\$
Regional Security Assessment Capability (5482)	235,000	27/11/2017	21/06/2018
	\$		\$
Regional SEEMail Implementation (3639)	450,000	02/07/2018	29/06/2019
	\$		\$
	88,902	02/05/2016	31/05/2018
			88,891

	\$		\$
Regional Self Service Kiosk Access (4702)	99,000	27/06/2016	03/05/2018
Regional Self-service Reset for Windows Domain User Account Password (4852)	\$ 155,120	02/11/2016	30/06/2018
Regional Server Switch Replacement - Grafton (4939)	\$ 336,000	13/02/2017	27/07/2018
Regional SharePoint Review (5206)	\$ 20,880	14/11/2017	12/03/2018
Regional SpectrumScale Backup (5383)	\$ 217,000	18/04/2018	01/10/2018
Regional SQL Legacy Database Migration (4920)	\$ 145,750	16/01/2017	30/12/2018
Regional SQL Server Reporting Services 2014 (4888)	\$ 327,000	28/01/2017	31/12/2018
Regional Storage Tier 1 Growth - Disks (5160)	\$ 173,000	02/08/2017	16/03/2018
Regional Support for the ADHB-WDHB Contact Centre Collaboration Project initiative (3711)	\$ 634,300	25/10/2013	04/12/2017
Regional Telehealth Project (4760)	\$ 272,707	13/08/2016	31/08/2018
Regional Tier 1 Grafton Storage Growth (5033)	\$ 495,000	02/06/2017	16/03/2018
Regional Tier 1 MMH XIV Gen2 Storage Replacement (4929)	\$ 850,000	25/10/2016	12/06/2018
Regional Upgrade Desktop Browser to IE11 (4240)	\$ 1,376,871	02/07/2015	31/07/2017
Regional UPS Hardware Replacement Feb16 (4670)	\$ 400,000	02/02/2016	19/07/2017
Regional Virtual Server Resource Recovery (4961)	\$ 260,000	01/03/2017	28/07/2018
Regional VMware Farm ESX Capacity Expansion (4925)	\$ 185,000	02/11/2016	11/08/2017
Regional VMWare Increased Resilience (4994)	\$ 93,000	22/04/2017	18/12/2017
Regional WAN Link Replacement FY1819 (5413)	\$ -	02/07/2018	31/01/2019
Regional WannaCry Response (5058)	\$ 195,000	01/05/2017	31/07/2017
Regional Wi-Fi deployment across DHB sites (3806)	\$ 4,126,824	17/02/2014	31/07/2017
Regional WiFi Network Expansion – Resilience and Performance (4848)	\$ 330,000	02/10/2016	19/07/2017
Regional Wi-Fi Trusted Access (4936)	\$ 116,000	13/02/2017	28/07/2018
Regional Wireless LAN Controller Upgrade (5470)	\$ -	02/07/2018	01/12/2018
Regional XaaS hA Target Operating Model (5148)	\$ 300,000	02/07/2017	01/07/2018
Regional XenMobile Resilience (5010)	\$ 236,151	01/05/2017	31/08/2017
Regional Xero License Uplift (5393)	\$ 51,999	09/04/2018	29/06/2018

Regional XenMobile Resilience (5010)	209,676.35	May-17	May-17	209,676.35
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Question 41 – Appendix 1

PREGNANCY AND PARENTING EVALUATION REPORT: EXECUTIVE SUMMARY



- The Pregnancy and Parenting Education Services**
- Publicly funded services delivered across ADHB and WDHB, designed to provide mothers to be, their partners and whānau with education and information related to pregnancy and parenting.
 - Targets first time mothers; Key target groups are teenagers, Māori, Pacific Peoples, Asian, refugees, and prospective parents for whom English is a second language.
 - Target of reaching 30% of pregnant women in target groups and 30% coverage for total population.
 - Two components: Education Component (group education classes) and Information Component (Mokopuna Ora website and app).
 - ADHB also provides opportunistic education and home visits in addition to the classes.

A mixed methods evaluation approach

Synergia conducted a formative process and initial outcome evaluation of the Services. The evaluation aimed to understand the implementation and outcomes of the Services, with a focus on the Services' progress toward meeting the needs of target groups.

A mixed methods approach was used drawing on a range of data sources, including focus groups/interviews with class participants, interviews with key stakeholders, DHB service data, DHB birth rate data and Mokopuna Ora website and app usage data.

Services assessed and service costs

3698 women across ADHB and WDHB received pregnancy and parenting education.



57% attended group education classes



41% received opportunistic education during a clinical visit



2% had home visits from a child birth educator (CBE).

The number of hours of group education delivered per woman was 6 hours at ADHB and at least 12 hours at WDHB (with some rural maternity units providing more than 12 hours). This is reflected in the higher cost per woman of delivering the WDHB services compared to ADHB services.

ADHB:
\$136



WDHB:
\$238



Access to classes by ethnicity and age

Most women attending classes are Asian or European¹ (n=2057). Only 3% of attendees are younger mothers (aged 20 years and younger; n=121).



Reaching women in key target groups

WDHB classes are reaching² 30% of the total population. ADHB classes achieve the 30% target when all services are considered (classes, opportunistic education and home visits). Reach for the classes alone is 9%.

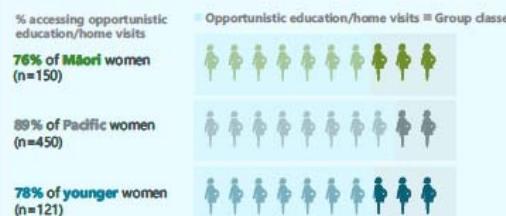
The analysis of service reach identified the following progress toward reaching 30% of pregnant women in target groups.

- WDHB is achieving the target for Asian women (31% reached). WDHB is also reaching 19% of Pacific women.
- When group classes alone are considered, ADHB is not achieving the target for Māori, Pacific or Asian women, however participation of these groups in classes has increased over time.
- WDHB and ADHB classes are reaching similar percentages of mothers aged 20 and under (10% and 13% respectively).
- When all services offered by ADHB considered (classes, opportunistic education and home visits), ADHB is reaching over 30% of Māori (41%) and Pacific (55%) ethnic groups, and is approaching the target for Asian ethnic groups (28%). ADHB is also reaching 64% of mothers aged 20 and under through its range of services.

Differences between the DHBs in the reach of classes may partially reflect differences in maternal demographics; ADHB as a higher number of Pacific and Asian women giving birth than WDHB, while WDHB has a higher number of Māori and "Other" women giving birth. This finding highlights the challenge for DHBs of expanding their reach to key target groups and the importance of appropriate resourcing to ensure that DHBs are able to meet target group demand for services in their region.

Value of opportunistic education and home visits for reaching target groups: ADHB

The infographic below identifies the number of Māori, Pacific and younger women (aged 20 and under) accessing opportunistic education/home visits as a percentage of all those accessing any ADHB service. While these services support reach for key target groups, further exploration of the value of these sessions for women is needed as they can be much shorter than group classes and do not cover as wide a range of topics.



Key strengths and benefits of the Services

- CBEs were generally perceived positively by participants.
- Participants learned more about their pregnancy through the classes.

97% of survey participants agreed or strongly agreed that their educator was well prepared and knowledgeable. (n=409)

95% of survey participants agreed or strongly agreed that they felt more informed about their pregnancy after the classes (n=407).

- Participants view pregnancy in a positive way and perceive labour and breastfeeding as natural and normal.
 - Some participants wanted more information on other possibilities and options e.g. what to expect if they had to have a caesarian section, other options for feeding.
- Information perceived as valuable by participants: 98% of participants felt that the information provided during the course was useful (n=427). Participants found the information about labour and birth the most helpful.
 - Some participants also wanted more information about caring for the baby after it is born and what changes to their bodies to expect post-birth.

"I think most first-time mums are worried about the labour. It was useful to have someone say, this is what you can expect, this is what I am going to have to handle." (Antenatal class participant)

"She explained this is what people think birth is, and this is what it actually is...So, when she said, it's not like the movies...She had my attention from there." (Antenatal class participant)

Key considerations

- Continue to increase capacity to respond to the needs of Māori, which could include increasing availability of Kaupapa Māori classes
- Explore opportunities to provide culturally-appropriate education for Pacific parents
- Continue to work with local providers to support improved engagement of teen parents and migrants
- Continue to use opportunistic approaches to delivering pregnancy and parenting education. This will be important in continuing to reach target groups.
- Expand opportunities for social interaction and the development of social networks
- Review messaging around immunisation so that all CBEs are delivering messages according to national immunisation guidelines
- Continue to provide class participants with balanced and evidence-based information about options available for birthing and feeding
- Consider reviewing the promotion, content and use of the Mokopuna Ora website and app
- Improve the consistency of monitoring and reporting of attendance and birth rate data, including the collection of ethnicity data and age data
- Capture the perspectives of women who have received opportunistic education and home visits

¹Data on European ethnicities, including New Zealand European, were aggregated to enable comparisons between the DHBs, as some services did not provide data split by NZ European and other European ethnicities.

²Reach was estimated by expressing the number of women who accessed the services in each target group as a proportion of all women who gave birth in that target group. Birth rate data from 2016 (live births only) was used for this analysis.

Question 41 – Appendix 2

Pregnancy and Parenting Education Services: Evaluation report

Report for Auckland District Health Board and Waitematā
District Health Board

Dr Sarah Appleton-Dyer

Alanna Soupen

Nishadie Edirisuriya

18 September 2017

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Synergia would like to acknowledge the support of the key stakeholders that took part in this evaluation. We would particularly like to thank all the participants who had taken part in the Pregnancy and Parenting Education Services across the Auckland District Health Board (ADHB) and Waitemata District Health Board (WDHB) regions. We appreciate the time they took to engage with us while pregnant or post birth.

We would like to thank the ADHB and WDHB staff, and the staff involved in the Pregnancy and Parenting Education services across the regions that took part in their evaluation. We valued their time and insights on the services.

The views and experiences of all stakeholders have enabled the evaluation to provide a comprehensive insight into the Education service, as well as considerations for refinements and improvements to the services going forward.

Synergia would also like to recognise the partnership and expertise of Debbie Goodwin. Debbie works as a member of the Tuakana Teina Evaluation Collective, as an evaluation consultant / researcher, and is a Director of DBZ Consultancy Ltd. Debbie is from Tūhoe / Whakatōhea Iwi.

EXECUTIVE SUMMARY

The Pregnancy and Parenting Education Services

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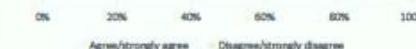
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Key considerations

- Continue to increase capacity to respond to the needs of Māori, which could include increasing availability of Kaupapa Māori classes.
- Explore opportunities to provide culturally-appropriate education for Pacific parents.
- Continue to work with local providers to support improved engagement of twin parents and migrants.
- Continue to use opportunistic approaches to delivering pregnancy and parenting education. This will be important in continuing to reach target groups.
- Expand opportunities for social interaction and the development of social networks.
- Review messaging around communication so that all CBEs are delivering messages according to national immunisation guidelines.
- Continue to provide class participants with balanced and evidence-based information about options available for birthing and feeding.
- Consider reviewing the promotion, content and use of the Mokopuna Ora website and app.
- Improve the consistency of monitoring and reporting of attendance and birth rate data, including the collection of ethnicity data and age data.
- Capture the perspectives of women who have received opportunistic education and home visits.

1. INTRODUCTION

The Pregnancy and Parenting Education Services are publicly funded services designed to provide mothers to be, their partners and whānau with education and information related to pregnancy and parenting. The service targets first time mothers, which make up an estimated 40% of women who give birth across both DHB regions. Teenagers, Māori, Pacific Peoples, Asian, refugees, and prospective parents for whom English is a second language have been identified as key high-needs groups targeted by the service.

The overarching aims of the Services are to:

- Provide parents with information, education and support to help prepare them for pregnancy, childbirth and parenthood, and to enable them to make informed decisions.
- Provide parents with opportunities to share their experiences and form new social networks with other expectant parents.

The Services are delivered through Auckland DHB (ADHB) and Waitemata DHB (WDHB), in different services across each region. ADHB contracted Auckland DHB Women's Health to provide education services and several providers to support delivery of these services in the community. The Waitemata DHB provider arm is providing education in the Waitemata DHB district, along with the three Primary Maternity Units who provide services to the rural communities of Helensville, Warkworth and Wellsford. In addition to antenatal classes delivered across the DHB regions, ADHB and WDHB also delivered services tailored to specific population groups:

- **ADHB:** Kaupapa Māori classes and Mandarin-speaking classes. ADHB also provided opportunistic education to pregnant women attending appointments at the hospital or Greenlane Clinic and home visits.
- **WDHB:** Classes delivered to pregnant women in parts of rural Auckland.

To understand the implementation and outcomes of the Services, ADHB and WDHB's Planning and Funding team commissioned an evaluation. In July 2016, Synergia was contracted to provide a formative evaluation of the Services. This formative approach was designed to provide feedback while the Services were being delivered. This enabled feedback to support real time improvements to the Services.

A mixed methods approach was used, drawing on insights from quantitative and qualitative data sources to provide multiple levels of evidence on the delivery, outcomes and benefits of the Services. This report presents the findings of the evaluation.

1.1 Report structure

This introduction is followed by a brief overview of the background to the Services and a summary of the evaluation approach. The report then describes the level of access to the Services, participant satisfaction with the Services, key outcomes of the services and participants' perceptions of class delivery. The report concludes with the identification of key considerations to guide future development of the Services.

2. BACKGROUND AND CONTEXT

2.1 Context and need for pregnancy and parenting services

The transitional phase between life before children and becoming a parent is a period when pregnant women and expectant fathers are particularly responsive to and proactive in seeking health information. Pregnancy and parenting education can provide important benefits and opportunities that help meet parents' needs, including:

- Accessing information to help them prepare for labour and birth, early parenting and adopting healthy behaviours
- Meeting other parents, establishing social networks and increasing their social support, which may be particularly important for first-time parents or parents who are new to the area
- The opportunity for women with long periods between pregnancies or who have not previously attended antenatal classes to refresh or expand their knowledge
- Offering new couples who may have had children through previous relationships, the opportunity to participate in pregnancy and parenting education together.

Previous New Zealand research published by the Families Commission has indicated that only 41% of pregnant women attend pregnancy and parenting education classes.¹ Research exploring the maternity care pathway in New Zealand has also indicated that there is a need to improve way in which maternity services engage high-needs and diverse groups of women, including Māori and Pacific women:

- The Families Commission report found that attendees of pregnancy and parenting services are most likely to be NZ European, tertiary educated and high-income earners, while Māori and Pacific women are underrepresented. Cultural barriers, transport, childcare and language are key barriers to accessing pregnancy and parenting education for Māori and Pacific women
- Younger women can feel judged and stigmatised by staff interacting with them²
- Accessing support is difficult for women with low levels of literacy or limited English language skills.³

2.2 Service procurement and delivery

In 2015, the Ministry of Health (MoH) tier two national service specification for Maternity Services was revised to support improved access and acceptability of pregnancy and parenting education to high needs groups, with a specific focus on as younger, Māori, Pacific, Asian, immigrant and refugee mothers, including those with limited English language skills. A key target for the services outlined in the specification was for classes to reach 30% of pregnant women in each high needs group, as well as to achieve 30%

¹ Dwyer, S. (2009). Childbirth education: Antenatal education and transitions of maternity care in New Zealand.

² Pacific Perspectives Ltd. (2013). Maternity care experiences of teen, young, Māori, Pacific and vulnerable mothers at Counties Manukau Health. Wellington: Pacific Perspectives.

³ Pacific Perspectives Ltd. (2013).

coverage for the total population. This target can also be used as a proxy for the level of reach to first time mothers in the total population, as approximately 40% of births across the DHB regions are to first-time parents.

The specification includes two components for District Health Boards to fund:

- The Education Component, the MoH tier two national service specification for group pregnancy and parenting education classes
- The Information Component, which through mobile application(s) and other web-based means, is intended to provide information about key pregnancy and parenting topics free to all pregnant women, expectant fathers and parents/partners/whānau of new babies.
- The education and information components of these services are designed to supplement the education and information that pregnant women and their whānau receive from their Lead Maternity Carers (LMCs) and from other sources.

ADHB implemented a procurement process to secure a provider for the renewed Pregnancy and Parenting Education Service, where Auckland DHB Women's Health was selected as the successful provider. ADHB has also contracted several providers to support delivery of these services in the community. The WDHB provider arm is providing education in the WDHB district, along with the three Primary Maternity Units who provide services to the rural communities of Helensville, Warkworth and Wellsford. Table 1 outlines the different services provided through each DHB:

Table 1 Provision of Education Services provided across the ADHB and WDHB regions

DHB	Education Services provided
ADHB	<ul style="list-style-type: none"> • Mainstream antenatal classes across the ADHB region: <ul style="list-style-type: none"> - 6 hour block course - 2 x 3 hour classes • Opportunistic education to women attending antenatal appointments <ul style="list-style-type: none"> - At Greenlane Clinical Centre and Auckland City Hospital - At the Health Star Pacific clinic • Home visits for one on one education <ul style="list-style-type: none"> - Mainstream home visits - Kaupapa Māori service home visits • Kaupapa Māori classes • Mandarin classes (no longer contracted) • Teen parent classes
WDHB	<ul style="list-style-type: none"> • Mainstream antenatal classes across the WDHB region: <ul style="list-style-type: none"> - 6 x two hour classes - 4 x 3 hour classes • Primary Maternity Units providing services to the rural communities of Helensville, Warkworth and Wellsford • Mandarin classes

ADHB was also working with a local teen provider to deliver teen-focused pregnancy and parenting education, however Thrive struggled to engage young people and did not deliver any classes.

2.3 Key components of the Pregnancy and Parenting Education Services

The Service consists of an Education Component (antenatal classes) and Information Component. The Information Component, Mokopuna Ora was developed by Connectus, a consortium of providers at the University of Auckland. The Information Component includes an Education Core Curriculum for Child Birth Educators (CBEs) and Facilitators, primarily focussed on populations with high needs. Mokopuna Ora content can be accessed via the Mokopuna Ora website or mobile application.

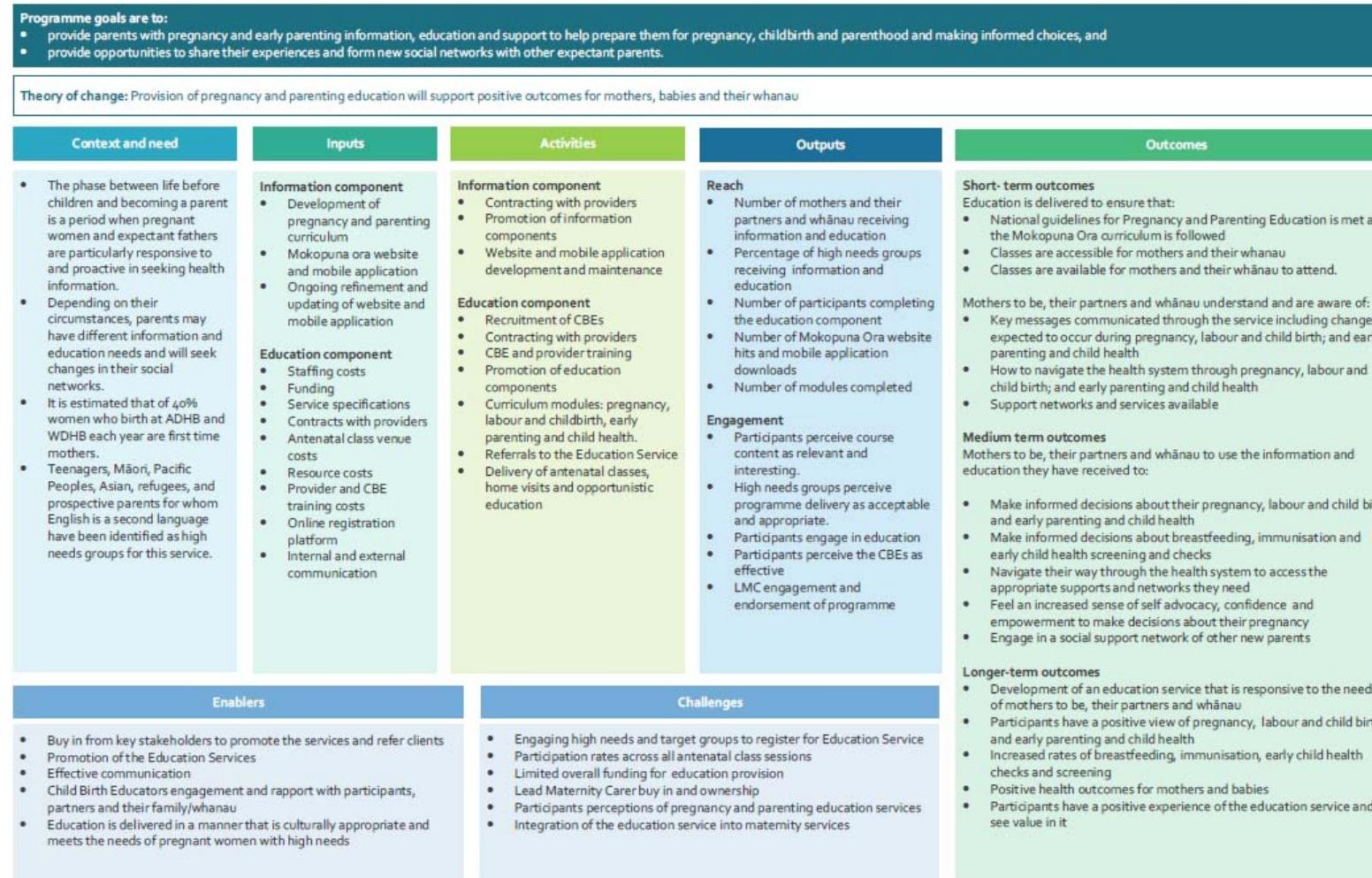
The Pregnancy and Parenting Education and Information components consists of a series of modules that cover:

- **Changes in pregnancy** - foetal development, supports and services
- **Healthy pregnancy** - healthy eating, exercise, and the effects of smoking, alcohol and drug use
- **Pregnancy care** - antenatal checks, screening, planning for birth, complications of pregnancy
- **Labour and birth** - choices and options, LMC, labour signs and stages, managing pain, birthing, complications and immediate care after birth
- **Postnatal care** - care for mother and baby, family support, body changes, rights and responsibilities
- **Breastfeeding and safe sleeping** - infant nutrition and safe sleep practices
- **Māori module** - narratives of mothers' experiences and considerations for Māori parents and whānau, and others interested
- **Teen pregnancy module** - focuses on meeting the needs of teenagers.

The logic model (Figure 1) identifies the key activities, inputs outputs and intended outcomes of the services. This model was used to focus the evaluation design and support a shared understanding of the Services.



Figure 1 Logic model for the Pregnancy and Parenting Education Services



2.4 Service costs

Table 2 shows the total cost of delivering the services for ADHB and WDHB, as well as the cost per woman based on the number of women who registered and attended at least one class. For ADHB, these figures also include the number of women who received opportunistic education or had a home visit and the associated costs.

Table 2 Service costs (per woman and total) for ADHB and WDHB, 2016-2017 financial year

DHB	Number of pregnant women reached	Total cost	Cost per woman
ADHB	2251	\$315,954.00	\$140.36
WDHB	1354	\$322,592.04	\$238.25

It is important to note that as most services did not record the number of partners and support people attending classes, the total number of people delivered to will exceed the numbers presented in the table.

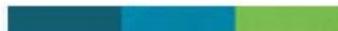
Table 3 provides a breakdown of the service costs in each delivery area in the WDHB region. The costs per woman were highest in Helensville and Wellsford. Please note that the figures presented for Helensville include the costs of delivering the core service as well as set up costs and the costs of early antenatal and post-natal education that were offered to participants.

Table 3 Service costs (per woman and total) across WDHB delivery areas⁴

Area	Number of pregnant women reached	Total cost	Cost per woman
WDHB metro region	1249 ⁵	\$273,000.00	\$218.57
Helensville	53	\$16,750.00	\$316.01
Warkworth	104	\$17,754.59	\$170.72
Wellsford	9	\$15,087.45	\$1676.19

⁴ The differences in costs per woman across the areas reflect differences in the services provided, with more education and support (e.g. postnatal classes and CBE management of Facebook pages) provided in the Helensville and Wellsford areas.

⁵ It is important to note that as most services did not record the number of partners and support people attending classes, the total number of people delivered to will exceed the numbers presented in the table.



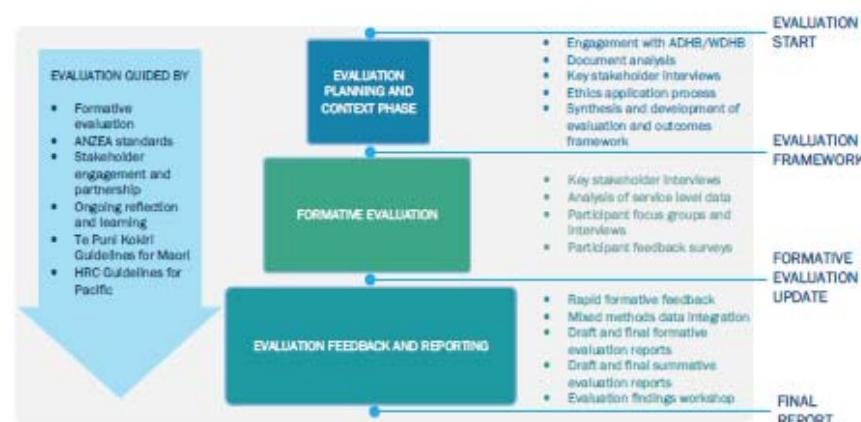
3. EVALUATION APPROACH AND METHODS

3.1 Evaluation approach and design

To support ongoing learning and improvement, Synergia adopted a formative evaluation approach. This supported ADHB and WDHB in understanding the implementation and outcomes during initial delivery of the Education Services, along with key insights from participants using the Information Component. The evaluation approach also provided insights to support the development of the services across the regions. This was particularly important following the changes to the services and their approach to delivery at the time of the evaluation.

The evaluation used a mixed-methods design. Figure 2 identifies the approach, methods and key phases of the evaluation, as well as the key ethical guidelines that supported the evaluation process.

Figure 2 Evaluation approach, methods and key phases



3.2 Evaluation aims and objectives

The evaluation aimed to conduct a formative process and initial outcome evaluation of the Services in ADHB and WDHB. The evaluation also identified specific process and outcome objectives to support a robust understanding of the implementation and outcomes of the Services (Table 4).

Table 4 Process and outcome objectives of the evaluation**Process evaluation objectives:**

- Identify the context of the Pregnancy and Parenting Education Services including:
 - Number of referrals
 - Number accessing the Services, including an analysis by key target groups
 - Referral pathways and how participants access the services
 - Level of flexibility provided to support women engaging in the Services
- Identify whether the Services are delivered in line with the new MoH contract and associated model, including exploring:
 - Reach and access for target populations
 - Dosage of the education services
- Identify barriers and enablers to implementation of the Services
- Identify ideas for modifications and improvements

Outcome evaluation objectives:

- Identify if the Services meet the needs of the new parents, especially the needs of teens, Māori, Pacific, Asian and migrant women
- Assess the effectiveness of the Services through identifying increases in women and families' knowledge of key pregnancy and parenting topics
- Identify the key strengths and value the Services including:
 - Community capability and capacity to provide pregnancy and parenting education services
- Assess the maintenance of the services, including their ability to:
 - Continue as a learning programme that adapts to women and families' needs.
 - Maintain reach to its target populations

3.3 Evaluation methods

The evaluation used a mixed methods approach, drawing on multiple levels of evidence including data collected through the Services, feedback surveys from the Pregnancy and Parenting Education classes, stakeholder and participant interviews, and participant focus groups (Table 5).

Table 5 Evaluation methods, participants and sample sizes

Class participant and stakeholder engagement	
Method	Participants
5 focus groups and 2 phone interviews with antenatal class participants (pre-birth)	51
- Including one focus group with participants from the Kaupapa Māori class	
2 focus groups and 2 interviews with antenatal class participants (post-birth)	7
21 interviews with key stakeholders:	21
- Service managers	
- Child Birth Educators (CBEs)	
o One of the interviews was with the Mandarin class CBE	
- Lead Maternity Carers (LMCs)	
- University of Auckland	
Analysis of class feedback survey forms	
Service provider	Sample size
ADHB maternity provider arm	238
WDHB maternity provider arm	188
Helensville Birthing Centre	19
Warkworth/Wellsford birthing units	39
Usage data for the Mokopuna Ora website and app	
Component	Collection period
Website- Google Analytics data	April 2016- June 2017
App usage data	April 2016- June 2017
DHB Pregnancy & Parenting service data on women using the services	
DHB	Collection period
ADHB	July 2016- June 2017
WDHB	June 2016- June 2017
DHB 2016 birth rate data by ethnic group and age	
DHB	Collection period
ADHB	June 2016- June 2017
WDHB	June 2016- June 2017

Note: to distinguish between the different providers within the ADHB and WDHB regions, the term "ADHB metro region" and "WDHB metro region" have been used to describe

the areas where services were delivered by the DHB maternity provider arms. The term "rural Auckland communities" has been used to identify Helensville, Warkworth and Wellsford providers.

3.3.1 Limitations

The key limitations to consider in relation to this evaluation relate to:

- The ability to integrate survey responses across different providers and identify the ethnicity of respondents
- Engaging with mothers and families post-birth.

Each of these limitations are described in more detail below.

3.3.1.1 Integrating survey responses across different providers

The evaluation reviewed and collaboratively revised the surveys being used by the metro regions. While this supported integration of the data analysis for these two large regions, different surveys were used in the rural Auckland communities. This made it difficult to integrate the survey data to provide a view across ADHB and WDHB.

Given that participants from the DHB metro regions made up the majority of survey respondents and many of the rural surveys focused on open ended questions that collected qualitative data, the analysis is focused around the DHB metro region surveys. Therefore, the survey data analysis presented in this report largely reflects the feedback of ADHB and WDHB metro region participants.

There were however, some similarities between the metro region and rural surveys. These similarities supported us to include some of the Helensville survey questions relating to the following areas:

- Usefulness of the information provided in class
- The extent to which classes met their expectations
- How easy the educator was to understand
- Whether they would recommend the classes to others.

To ensure that feedback from across the rural areas of WDHB are not lost, we have incorporated the open-ended responses in the sections on suggestions for improvements and key considerations. It is important to note that ADHB's Kaupapa Māori provider did not use a feedback survey but used a participatory group discussion process to gain feedback from the class.

While not a specific limitation, it is useful to note that while a survey was distributed for women receiving home-visits, only eight responses to this survey were received. Responses reflected the feedback provided by group class participants, therefore, feedback from home visit participants has been integrated into the broader survey analysis.

3.3.1.2 Integrating attendance data across providers and DHBs

It is important to note that the different providers and DHBs collected attendance data differently, which made it challenging to integrate data across the services.

Footnotes have been provided in the report where relevant, to indicate if data was only available for some services or DHBs.

3.3.1.3 Identifying the value of the service for migrants and teen parents

The feedback survey and DHB service data did not capture whether participants reflected the key target groups; immigrants, refugees or second language English speakers. However, as the DHB service data grouped all European ethnic groups together, the 'Other' ethnic group category used in the DHB data is likely to represent women from a range of different ethnic groups.

The available data indicates that only one teen mother participated in the feedback survey across all the delivery regions. Engagement of teen parents in the focus groups was also very low. This may reflect some of the challenges experienced by the DHBs in engaging teen parents to participate in the antenatal classes.

3.3.1.4 Engaging new mothers post-birth

Given the challenges of being new parents, participants who had their babies found it difficult to commit to a follow-up interview or focus group. While telephone interviews were offered, it still proved difficult to connect with new families given the demands of supporting a new baby. To address the potential gap in the evaluation evidence, Synergia engaged with groups of mothers in Helensville, Warkworth and Wellsford through connecting with their coffee groups. These mothers tended to have older babies and provided a useful insight into the views and experiences of mothers' post-birth. Given the attendance at these groups, the insights from the key target groups of Māori, Pacific, and teens are not well reflected in this evaluation.

Despite these limitations, the evaluation evidence has provided a useful insight into the delivery and achievements of the Services so far. It has also provided a useful platform to consider ideas for future developments and considerations.

4. ACCESS TO THE PREGNANCY AND PARENTING EDUCATION SERVICE

3698 women across ADHB and WDHB received pregnancy and parenting education.

SERVICE USE BY DHB



** The term CBE refers to the Childbirth Educators who delivered the classes and home visits.

4.1 Engaging key target groups: class attendance by ethnicity and age

This section identifies how well group education classes are reaching high needs groups (including Māori, Pacific, Asian and teenage mothers). It is useful to note that ADHB expanded its services to further reach out to the key target groups. The attendance of the other services offered by ADHB provide some important insights into the services that were accessed by different groups (Section 4.2).

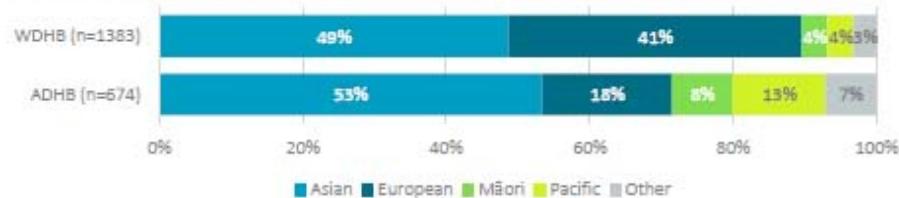
4.1.1 Access by ethnic group

There were some key differences between DHBs in access by ethnic group, with ADHB classes appearing to reach a more diverse group of women than WDHB classes⁶ (Figure 3):

- The percentage of Māori and Pacific women at ADHB classes was nearly twice that of WDHB classes.
- Over two fifths of women attending the WDHB classes were European (41%).
- Only 3% of WDHB women attending classes identified as 'Other', compared to 13% of ADHB women.

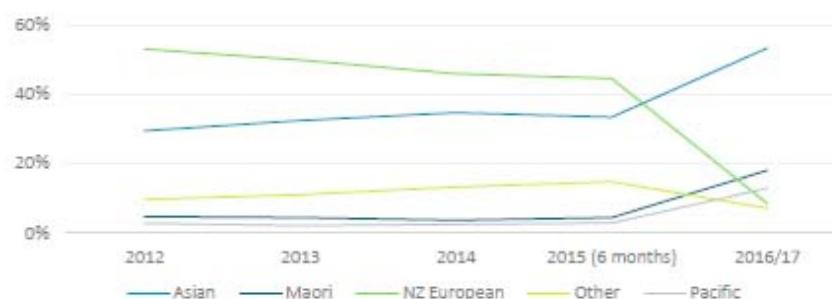
⁶ Please note that data on the ethnicity and age of pregnant women attending the classes was not collected in Wellsford. We have also assumed that the ethnicity figures provided by Helensville are for women only and not for all attendees.

Figure 3 Prioritised ethnicity of women attending group education classes by DHB



ADHB's historical data on class attendance by ethnic group shows that access for key target groups has improved following the introduction of the new MoH contract and associated model. Figure 4 shows that since 2015 in the ADHB region, the percentage of women attendees who identified as European decreased sharply while the percentage of women identifying as Asian, Māori and Pacific has increased. The decrease observed in the percentage of women who identified as 'Other' is likely to be due to changes in the way ethnicity is coded; in previous years non-NZ Europeans were classified as 'Other', whereas in the 2016/2017 data all European ethnic groups were grouped

Figure 4 ADHB class attendance by ethnicity over time



A similar analysis was not produced for WDHB as data on class attendance ethnicity prior to 2016 was only available for the rural community areas and one other provider (MAMA Inc.). Data on ethnicity is now being collected across WDHB services.

4.1.2 Younger mothers

Only 56 of the women attending group education classes were aged 20 years and under, representing 3% of all attendees. The participation of younger mothers was similar between ADHB (4%; n=675) and WDHB (3%; n=1249).⁷

⁷ This figure is for WDHB metro regions only as the other areas did not provide data on the number of class attendees aged 20 and under.

Additionally, four (7%) of the 52 women who registered and attended at least one class in the Helensville area were 18 years old or younger. While data was not available to indicate how many participants aged 20 years and under across all the areas were teen mothers, this data highlights the value of ADHB and WDHB continuing to work with local providers to reach younger age groups.

4.2 Additional services offered by ADHB

ADHB delivers pregnancy and parenting education through a mix of group education classes, home visits and opportunistic education, including:

- Mainstream, Mandarin and Kaupapa Māori classes⁸
- Mainstream and Kaupapa Māori home visits
- Mainstream opportunistic education as well as opportunistic education through Health Star Pacific.

Opportunistic educations and home visits are also used by CBEs to encourage women to attend group education classes. The following sections provide an analysis of attendance at these different services, including an analysis by the key target groups.

4.2.1 Engagement by ethnic group

Figure 5 identifies the percentage of women accessing the education services provided by ADHB (n=2251). Just under a third of women (30%) accessed education via a group education class (Mainstream, Kaupapa Māori or Mandarin class). The graph also shows that women were:

- most likely to receive information through opportunistic education (62% of women), and
- were more than twice as likely to receive opportunistic education than attend a group education class.

⁸ Separate analyses for each of these groups was not possible, as Synergia were only provided with aggregated attendance data for the Mandarin and mainstream classes

Figure 5 Percentage of women receiving each type of pregnancy and parenting education (ADHB)

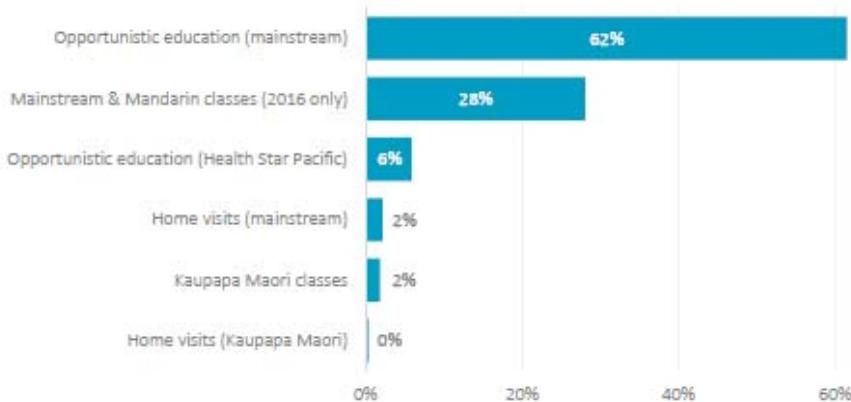


Table 6 shows that there were some key differences in the types of services accessed by different ethnic groups in ADHB:

- In comparison to the other ethnic groups, Asian women were most likely to attend mainstream and Mandarin classes.
 - They were also very likely to receive information via mainstream opportunistic education.
- Only about a tenth of Māori and Pacific women attended mainstream classes. These women were generally accessing information through the other services:
 - Over half of Māori and Pacific women received services through mainstream opportunistic education.
 - Less than a fifth of Māori women accessed Kaupapa Māori classes⁹.
 - Just over a quarter of Pacific women received opportunistic education through Health Star Pacific.
- European women mainly received pregnancy and parenting services via mainstream opportunistic education in the ADHB region.

⁹ It is important to note that this might also be a consequence of their limited availability across the region.

Table 7 identifies the overall reach of the services at each DHB, including the alternative services offered by ADHB. The table shows that when group education classes alone are considered, 30% reach is being achieved at WDHB only. When all services offered at ADHB are considered, ADHB also achieves 30% reach.

Table 7 Overall reach of pregnancy and parenting services across ADHB and WDHB

DHB	# live births in 2016	% women who registered and started attending group education classes	% women accessing any service (classes, opportunistic education or home visits)
ADHB	7555	9%	30%
WDHB	6926	30%	N/A

The following sections explore service reach for the service's key target groups as specified by the new MoH contract; target ethnic groups and younger mothers.

4.3.1 Service reach by ethnic group

Auckland DHB

At the time this report was prepared, the 30% target had not yet been reached for any of the target ethnic groups at ADHB (Figure 7). The bullet points below identify key insights from the reach analysis for different ethnic groups in ADHB:

- The percentage of Māori and Asian mothers attending classes is nearly three times as high as the percentage of European mothers.
- Only 6% of Pacific mothers are being reached by the classes.
- Over a quarter of women identifying with "Other" ethnicities are being reached by the classes, indicating that the classes are reaching women from diverse cultural backgrounds. It is unfortunate that we are not able to identify who are new migrants and those attendees for whom English is a second language, as the literature indicates greater barriers to access for these groups.¹⁰

¹⁰ Pacific Perspectives Ltd. (2013). Maternity care experiences of teen, young, Māori, Pacific and vulnerable mothers at Counties Manukau Health. Wellington: Pacific Perspectives.



Figure 7 Reach of pregnancy and parenting classes in ADHB for different ethnic groups, based on 2016 birth rate data

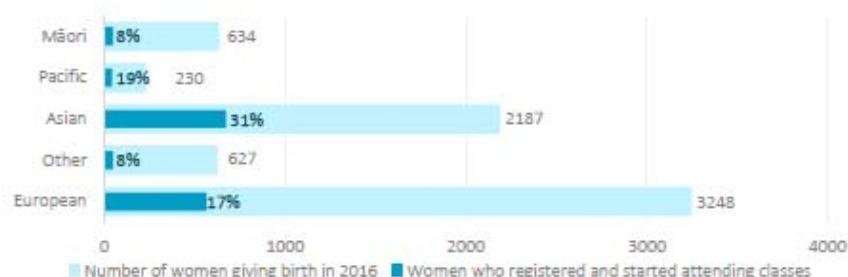


Waitemata DHB

WDHB is achieving the 30% target for Asian mothers, with the reach of group education classes for Asian mothers nearly twice as high than for the ADHB service (Figure 7). The bullets below identify additional insights from the WDHB analysis and key comparisons with ADHB.

- The WDHB classes reach nearly a fifth (19%) of all Pacific mothers. This is slightly higher than the percentage of European mothers reached (17%) by the WDHB classes and approximately three times the percentage of Pacific mothers reached by the ADHB classes.
- The percentage of Māori mothers reached by the WDHB classes is slightly lower than those reached by the ADHB classes (8% compared to 11% at ADHB).
- The reach of the classes for women who identify with "Other" ethnic groups is much lower than at ADHB (28% at WDHB compared to 72%).

Figure 8 Reach of pregnancy and parenting classes in WDHB for different ethnic groups, based on 2016 birth rate data



With the exception of European women, the differences in reach by ethnic group between the DHBs appear to reflect differences in maternal demographics at the DHBs:

- While ADHB had lower reach for Pacific and Asian women than WDHB, in 2016 ADHB had over three times as many Pacific women give birth compared to ADHB. It also had a larger number of Asian women giving birth.
- While WDHB had lower reach for Māori and "Other" women, in 2016 more Māori and "Other" women gave birth compared to ADHB.

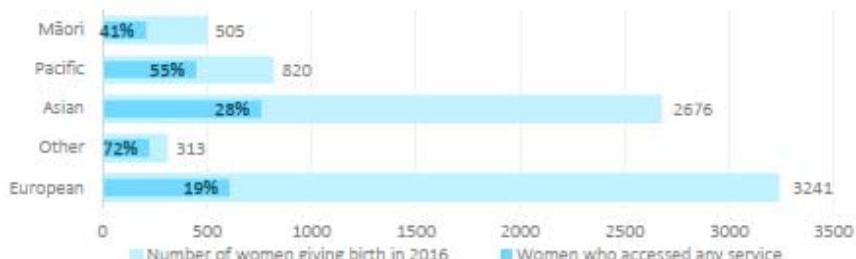
The differences in reach between the DHBs may therefore reflect the DHBs' challenges in expanding service reach for larger target groups within the resources available.

4.3.1.1 Reach of all services offered by ADHB

In response to the challenge of reaching key target groups, ADHB offered women opportunistic education and home visits, in addition to group education classes. When looking across all the different types of services available at ADHB (classes, opportunistic education and home visits), the reach of the services for key target groups exceeds or is similar to the reach of the WDHB group education classes:

- Over half (55%) of Pacific mothers and 41% of Māori mothers are being reached across the services provided by ADHB. Close to 30% of Asian women also being reached ([Error! Reference source not found.](#)).
- Additionally, nearly three quarters of women identifying as "Other" are reached across the different services offered by ADHB.

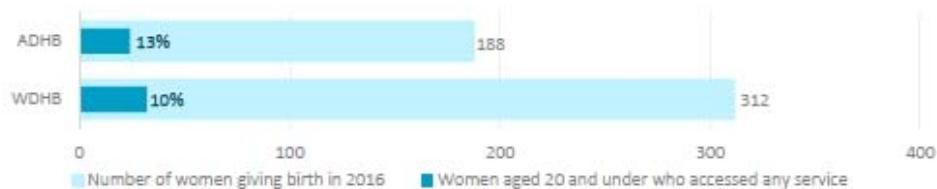
Figure 9 Reach of all pregnancy and parenting education services in ADHB for different ethnic groups, based on 2016 birth rate data



4.3.2 Service reach for younger mothers

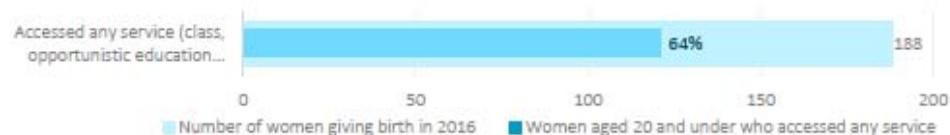
When analysing service reach for younger mothers (aged 20 and under), the 30% reach target is not being achieved when registration and attendance at group classes alone is considered, at either DHB ([Error! Reference source not found.](#)).

Figure 10 Reach of pregnancy and parenting education services in ADHB and WDHB for mothers aged 20 years old and under, based on 2016 birth rate data



For ADHB when access across all services is considered, the 30% target is exceeded, with 64% of the estimated number of mothers aged 20 and under accessing classes, opportunistic education or home visits (Figure 11).

Figure 11 Reach of all services (classes, opportunistic education and home visits) in the ADHB region for mothers aged 20 years old and under, based on 2016 birth rate data



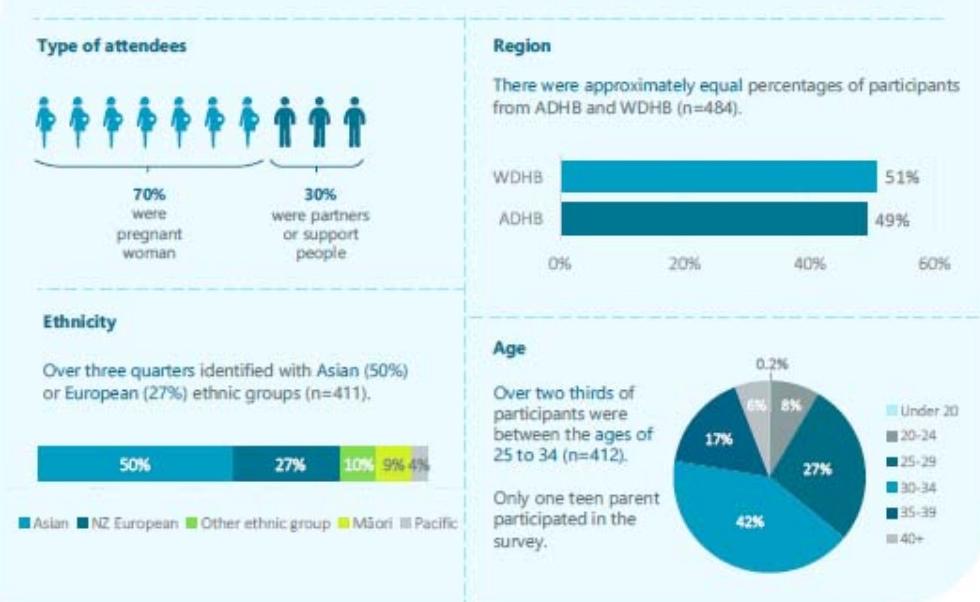
These findings further highlight the value of offering a wider range of services in reaching key target groups and achieving the 30% target set out by the new MoH contract and associated model, particularly for Māori mothers and younger mothers who have low participation in mainstream group classes.

5. FEEDBACK SURVEY PARTICIPANTS

The infographic provides an overview of the key characteristics of those who participated in the class feedback survey. Please note that a response rate could not be calculated as data was not provided on the total number of surveys distributed.

The survey was distributed by CBEs to all class participants and completed retrospectively. Note: information on ethnicity and age was not available for some participants.

484 prospective parents who attended a group education class participated in the class feedback survey.

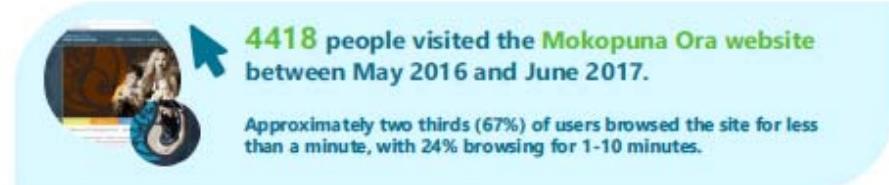


The infographic indicates low participation in the survey from Māori, Pacific and 'Other' women, and teenage pregnant women. This is likely to reflect lower participation of these groups in the classes and higher engagement with opportunistic education and home visits. Additionally, the ADHB Māori provider did not use a feedback survey with the Kaupapa Māori classes, instead using in-class participatory activities to gather participant feedback. An approach such as this may also be useful for gaining feedback from teen parents-to-be.

6. USE OF THE MOKOPUNA ORA WEBSITE AND APP

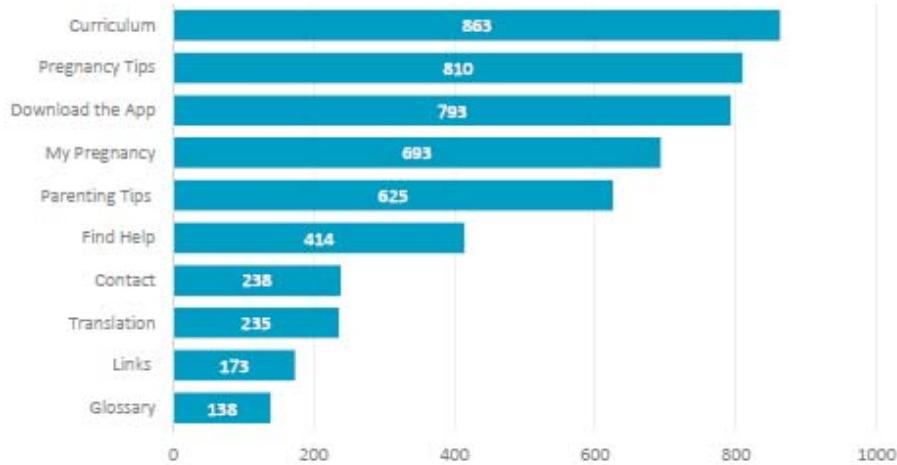
The information component of the Services was designed and delivered by Connectus through the Mokopuna Ora website and App. To understand the role and value of this aspect of the Education Services, this section focuses on the use of the website and app, and their perceived value and ideas for improvements.

6.1.1 Use of the website



Data on the use of the Mokopuna Ora website was extracted through Google Analytics, from the time of the website's launch in May 2016 to the end of June 2017. Figure 12 identifies the unique page views for each of the main website pages (excluding the home page). The most popular pages were the Curriculum, Pregnancy Tips and Download the App pages. Although the website contains valuable information on local support services, the Find Help and Links pages had fewer unique page views.

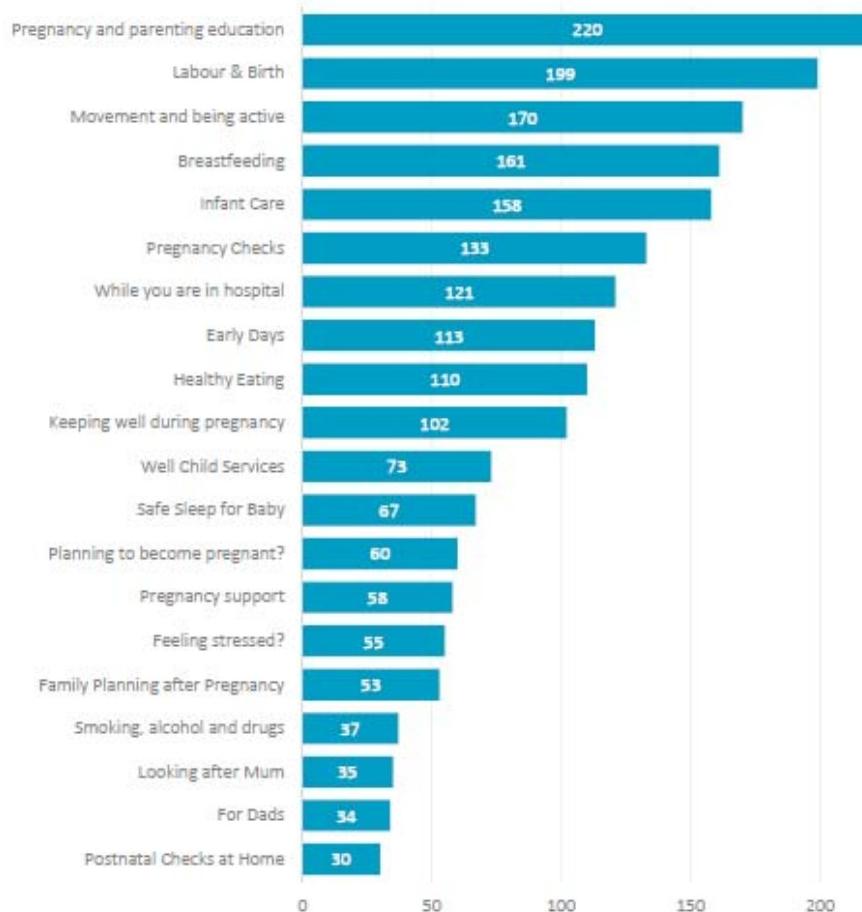
Figure 12 Unique page views for each of the main website pages



The website was also intended to be used by parents as a source of reliable, localised evidence-based information to support them through pregnancy and early parenting. To gain an insight into the areas parents were most interested in, the unique page views for the Pregnancy Tips and Parenting Tips subpages were also extracted (Figure 13).

The graph shows that the subpages for pregnancy and parenting education, labour and birth and movement and being active during pregnancy had the most unique page views.

Figure 13 Unique page views for the Pregnancy Tips and Parenting Tips subpages May 2016 – June 2017



These findings indicate that users do show an initial interest in the website and particularly the information provided on pregnancy and parenting. Website visitors however, do not spend a long time viewing the pages. It would be useful to conduct a pop up survey with people who are exiting the site after a short period to understand the reasons behind this. For example, did they find what the information that they were looking for or did they go on to search somewhere else.

6.1.2 Use of the app

The Mokopuna Ora app was launched in May 2016. Between May 2016 and the end of June 2017, 523 users installed and registered with the app. Figure 14 shows how the number of users who installed and registered the app changed over time with a large drop in September 2016 and then a more consistent pattern of approximately 38 users per month during 2017.

Figure 14 Number of users who installed and registered with the app, May 2016 to June 2017

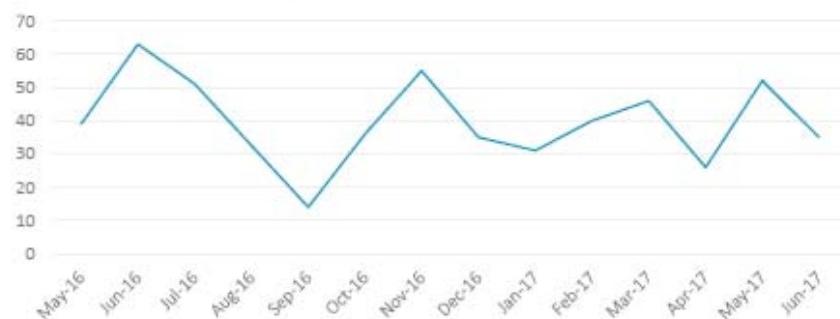
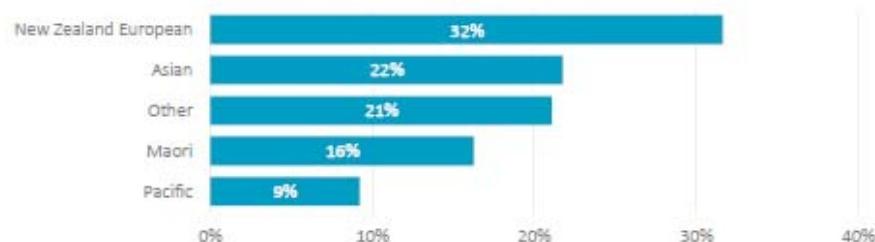


Figure 15 shows the ethnic groups of those who registered and installed the app.¹¹ Note: 68 users did not specify their ethnicity.

Figure 15 Breakdown of users by ethnic group (n=455)



The app also collected some health information with users when they completed their registration (n=523):

- 85% of users said they had a midwife,
- 6% were smokers, and

¹¹ Users selected from a wider range of ethnic group options which were aggregated into the five categories displayed on the graph. Only limited options were available for Asian ethnic groups (only Chinese and Indian) and Pacific ethnic groups (Samoan, Tongan, Niuean, Cook Island Māori).

- 16% lived in a household with smokers.

In the future, it would be useful to use this data gathering exercise within the website as an opportunity to provide people with information relating to their specific needs. For example, a pop-up could note that you indicated that you do not have a midwife, to find more about accessing a midwife in your area click here. This would support people in accessing information that relates to their individual needs.

6.1.3

Perceived value of the app and website

Insights from focus groups/interviews and the feedback surveys indicated that most participants did not use the website or app and at that stage of their pregnancy were already using other websites, apps and resources (such as books, pamphlets and information from their midwives) including:

- Other apps e.g. Baby Centre, Wonder Weeks, Ovia, BreastFeed NZ, Bounty, Sprout, Bump. Participants were happy with these apps and felt that they met their needs well.
- Websites e.g. whattoexpect.com, labourpains.com
- Pregnancy and parenting-related books
- Information and resources provided by their LMCs
- Google searches
- YouTube e.g. for videos on how to change a diaper
- Advice from friends and family

Participants in some classes were not aware of the app and website, or only recalled it being mentioned briefly during class. The results of the feedback surveys across the ADHB and WDHB metro regions reflect these findings, as only about a third of participants indicated that the app and website were useful (Figure 16).

Figure 16 Usefulness of the Mokopuna Ora app and website (ADHB and WDHB metro regions only only)



It is important to note that as the information on the app and website is only available in English and Māori, participants who have limited English language skills are unlikely to be able to draw on Mokopuna Ora resources for support. This was identified as an issue particularly for the classes delivered in Mandarin, where most participants were new migrants with limited English language skills. These participants were already using different apps and resources that provided information in Mandarin, some of which were developed in their countries of origin.

7. GROUP EDUCATION CLASSES

This section focuses on the feedback from the surveys completed at the group education classes. This analysis has supported us to explore motivation to attend classes, completion and satisfaction.

7.1 Motivation to engage in the group education classes

Participants of the focus groups and interviews identified the following key reasons for wanting to attend classes:

- **Improving their knowledge:** Most participants were first-time parents and wanted to know more about pregnancy, childbirth and looking after the baby post birth.
- **Free provision of classes:** The free provision of the classes was a key motivating factor for participants to attend the classes.
 - Some services also provided transport and food so that direct costs of attending are minimised.
 - The CBE delivering the Mandarin classes highlighted the free provision of the services as important in engaging the Chinese community.
- **Establishing social networks:** Participants wanted to network with other mothers and new parents to make new friends. They also wanted to establish coffee groups for support after giving birth.
- **Venue and timing of classes:** The proximity of the classes to participants' homes and the ability to choose a class that suited them and their work schedule were important factors influencing participants' decision to attend. The delivery structure of the classes was also an influencing factor:
 - Some participants who attended the six-hour class chose the class because it was on a weekend day and because they did not have to attend classes over several days. However, it is important to note that participants also felt that six hours was not enough time to cover all the content in sufficient depth.
- **Tailoring delivery or content to specific cultural groups**
 - The Kaupapa Māori approach used by Ngati Whatua was one of the key reasons participants wanted to participate in the classes. The inclusion of Te Reo, karakia, waiata and specific matauranga Māori with regards to pregnancy, childbirth and parenting was an important reason for attendance by Māori mothers to be and families.
 - Offering classes in Mandarin was an important enabler to Chinese women and their partners engaging with the service.

"Having the educator able to speak a language from our own community. It helps us to understand the process and likely issues and comfort us during the pregnancy period." (Antenatal class participant)

"This is a Chinese course which is easy for me to understand." (Antenatal class participant)

Following the home visits, four of the eight participants indicated that they planned to attend group education classes suggesting that the visit had motivated them to find out more. However, it is not clear whether these women attended classes.

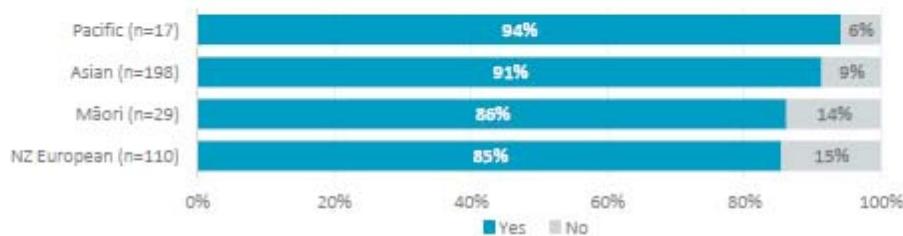
7.2 Course completion

Data on the number of women who completed at least 75% of the group education classes was available for the ADHB and WDHB metro regions, with similar rates of completion evident at both DHBs:

- 81% of ADHB women who registered for the classes (including Kaupapa Māori classes and Mandarin classes) completed at least 75% of the classes.
- 83% of WDHB women who registered for the classes completed least 75% of the classes (including Mandarin classes).

The class feedback survey also asked participants about their level of attendance. Across both the ADHB and WDHB metro regions, 89% of participants said that they attended all the classes they booked for, higher than indicated by the DHB service data ($n=400$). The feedback survey also indicated that attendance was high (85% or over) across all ethnic groups and age groups. Compared to NZ European participants, Asian and Pacific participants were slightly more likely to say they had attended all the classes (Figure 17).

Figure 17 "Did you attend all the classes you booked for?" - by ethnic group (ADHB and WDHB metro regions only only)

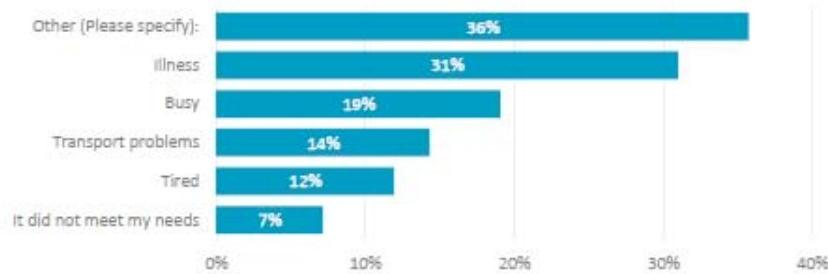


Of the 11% (43 participants) who said they did not attend all the classes they booked for, 39 were from the WDHB metro region and four were from the ADHB metro region. This may reflect the different delivery arrangements of each DHBs; WDHB metro region classes were delivered over either four or six sessions, whereas ADHB delivered classes in either one six-hour block session or two three-hour sessions.

7.2.1 Reasons for non-attendance

Of those ADHB and WDHB participants did not attend all classes, 36% selected 'other' as the reason, 31% did not attend due to illness and 19% indicated that they were busy ($n=42$; Figure 18).

Figure 18 Reasons for not attending all the classes booked (ADHB and WDHB metro regions only only)



'Other' reasons for non-attendance identified by participants included:

- Baby arrived early (3 participants)
- Work obligations (3 participants)
- Other commitments (3 participants)
- The following were identified by one participant each:
 - Finding the classes boring
 - Traffic
 - Doctor's appointment at the same time
 - Home obligations
 - The length of the classes.

The survey findings reflected the feedback provided through the focus groups/interviews, where participants and stakeholders noted that sometimes mothers and whānau are too busy, have other appointments and/or are too tired to come to all the classes. It is useful to note that the Kaupapa Māori education classes, encouraged participants to attend after baby is born even if they missed classes. This reinforced the connection with others and the opportunity to hear key messages.

The focus groups/interviews also provided additional insights into the barriers to attending class:

- Some mothers did not attend all the classes because they thought that they could get all the support they needed from their whānau and friends. Others had whānau who made them feel like they did not need to access the classes.
- It can be difficult for single mothers to attend these classes as they feel isolated and some stop coming to the classes.

8. KEY OUTCOMES: IMPROVED KNOWLEDGE AND AWARENESS

This section provides participants' perspectives on their learning across the classes' two key content areas; pregnancy, labour and childbirth, and early parenting and child health. It reflects the key themes from the focus groups with group education class participants as well as the feedback surveys with group education and home visit participants.

8.1 Pregnancy, labour and childbirth

Nearly all survey participants across the ADHB and WDHB metro regions (95%; n=407) felt more informed about their pregnancy because of the classes. However, there were some differences between the different regions in how prepared women felt for labour and childbirth after the classes:

- Participants engaged post-birth at the rural community sites said they felt well-prepared and much less anxious about labour after the class.

"I felt really prepared and confident...she made it seem like a challenge. I was almost looking forward to it." (Antenatal class participant)

"She was really good at preparing you that anything can happen...whatever happens is normal - there's no normal so therefore it's all okay." (Antenatal class participant)

- Participants engaged at the ADHB and WDHB metro regions (the majority engaged pre-birth) felt that they were well-informed and better prepared than before they attended the classes, but did not feel that any amount of information provided could prepare them for the experiences of childbirth and labour.

"It doesn't matter how much information you're getting, you're never going to be prepared, ever... it was a good, solid foundation...the basics." (Antenatal class participant)

"I feel more prepared...I don't think you'll ever be one hundred percent fully prepared but I think it's helped." (Antenatal class participant)

These differences may reflect the different delivery structures and support available across the different regions:

- Classes delivered by community providers were delivered over longer periods of time in smaller groups. This allowed for more time for demonstrations, group discussion and practical exercises (e.g. hypnobirthing or breathing exercises).
- The establishment of Facebook groups and networks between participants was more successful in the rural community areas. These may have facilitated better peer support for participants before their babies were born.

8.1.1 Natural births and medical interventions

It was interesting to note that although most participants felt well informed about labour and childbirth, those who planned natural births and experienced complications (e.g. had to have an induction or emergency C-section) did not feel prepared for these experiences:

- Two participants thought that this could be because they planned on having natural births and did not focus enough on the content related to medical intervention during class.
- One participant felt that the class did not provide enough information on C-sections.

As labour and childbirth can be unpredictable experiences, classes may have a role to play in supporting women in understanding and managing potential changes to their birth plans. This was another area where participants suggested that bringing in new mums to share their experiences would have been beneficial.

"It would have been good to have more examples and personal stories about pregnancy and birth and different scenarios that could happen." (Antenatal class participant)

8.2 Facilitating access to a social support network

Educators generally helped to facilitate the establishment of a support network through setting up a class Facebook page that participants could use to connect after they gave birth, and encouraging participants to start new parent coffee groups. The following sections identify the perceived value and benefits of connecting with other first-time parents pre-birth, and belonging to coffee groups post-birth.

8.2.1 Perceived value pre-birth of connecting with other first-time parents

At the focus groups/interviews conducted pre-birth, participants generally were open to the idea of a coffee group. Some participants were unsure about whether they would attend coffee groups, due to not living close to the other participants, concerns over not having enough time once the baby was born or because they already had a social support network.

This variation was reflected in the findings of the feedback survey across the ADHB and WDHB metro regions, where just over two thirds of participants said that the classes had helped them to connect with new people and approximately a fifth said that they were neutral (Figure 19). Some of the neutral responses might also reflect the time at which this

information was gathered, as some people may not have had the opportunity to connect with one another yet due to the shorter nature of some of the courses.

Figure 19 "The course helped me meet new people to stay in touch with during my pregnancy and as a new parent" (ADHB and WDHB metro regions only)



The following subsections explore this feedback further through crosstabs of responses by DHB, ethnicity and age group.

8.2.1.1 Differences between DHB metro regions

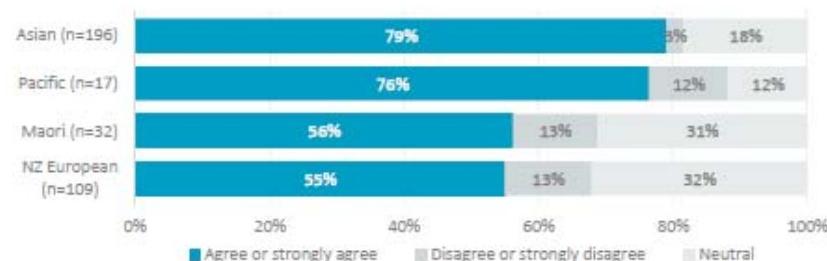
ADHB participants were more likely than WDHB participants to say that the classes had helped them connect with new people:

- 74% of ADHB participants (n=224) agreed/strongly agreed that the course helped them to meet new people to stay in touch with during their pregnancy, compared to 62% of WDHB participants (n=172).

8.2.1.2 Ethnic group differences

Compared to NZ European participants, Pacific and Asian participants were more likely to say that the classes had helped them to meet new people (Figure 20). The responses of Māori and NZ European participants were similar.

Figure 20 "The course helped me meet new people to stay in touch with during my pregnancy and as a new parent"- by ethnic group (ADHB and WDHB metro regions only)



8.2.1.3 Age group differences

Participants aged 35-40+ were less likely to say that the classes helped them meet new people (61%; n=87) compared to those aged 20-34 (72%, n=305).

8.2.2

Establishment and perceived value of coffee groups post-birth

Coffee groups were established post-birth across the different sites and service providers. Some of the participants involved in the focus groups/interviews attended a coffee group. These were better established in rural communities, which were also more likely to have active Facebook pages. The following were perceived as the key benefits of being part of a group:

- Being connected to a support network of people who they can relate to and understand their experiences

"It's just having people that are going through the same thing at the same time as you, and sort of just get it...everyone's in it together." (Antenatal class participant)

"If you have a question being able to get support e.g. is that normal, what do you do about sleep and feeding etc...you don't get worried because you know its normal." (Antenatal class participant)

- Providing support for women without an existing support network or who feel isolated
- The potential role for coffee groups to help support women experiencing postnatal depression, as well as their partners
- Sharing information and ideas about what to purchase for their baby:

"People tell you about things going on, like 'oh there's sale on for kids' stuff here' ... 'what kind of car seat are you going to get?'...You can get real feedback from real people...not just advertising." (Antenatal class participant)

8.2.3

Child Birth Educator facilitated coffee groups

Some coffee groups were established by CBEs and provided ongoing education on early parenting for new mothers. CBEs delivered some of the education on early parenting (e.g. breastfeeding, introducing solids) but also invited guest speakers, including a physiotherapist to provide mothers with information on pelvic strengthening exercises and massage.

Support from the CBEs in establishing these groups was linked to greater engagement and attendance, and success was particularly evident in the Helensville and Warkworth/Wellsford areas.

Classes in these areas were also smaller, which participants felt made it easier to get to know one each other and to develop relationships with people. This may be more difficult in the ADHB and WDHB metro region classes, some of which had high volumes, with people from across the DHB region and with less time to connect with each other:



"There are only five classes...to cover all that information but then still leave time for people to have a sense of chat, get to know each other, I think it's not possible really. You're going to miss information if the class is going to try to achieve both."
(Antenatal class participant)

It is important to note that although the coffee groups and Facebook groups worked well in the rural communities for those who engaged, immigrant women who attended the classes did not engage in these groups. Although it was noted by staff that these communities may have other support networks to draw on, this highlighted the importance of continuing to reach out to migrant parents, particularly in rural areas where they may feel more isolated and may have access to fewer other support services.



9. PARTICIPANT SATISFACTION WITH THE SERVICE

Overall, participants across the ADHB and WDHB metro regions and Helensville were highly satisfied with the information provided by the classes that they attended.

Over 90% of survey participants (n=427) agreed or strongly agreed that:



The feedback from home visit participants also indicated a high level of satisfaction with the education they received, with all eight participants indicating that the information provided was useful.

Drawing on the feedback surveys across the ADHB and WDHB metro regions only, the following sections explore participants' satisfaction with the level of information provided, the information that participants found most useful and areas where they would have liked more information or support.

9.1 Providing an appropriate level of information across the key content areas

Most participants were satisfied with the level of information provided across all the key content areas of the classes. Table 8 identifies the areas where there were very high levels of satisfaction with the information provided (90% or more participants agree/strongly agree) and high levels of satisfaction (80-90% agree/strongly agree).

Table 8 Reported levels of satisfaction across content provided in key areas (ADHB and WDHB metro regions only)

Participant satisfaction	Area	Percentage	N
Very high	Their pregnancy	97%	387
	Labour and birth	96%	398
	Breastfeeding	92%	370
	Safe sleep	91%	371
High	Services and support available in their community	86%	381
	Early parenting	85%	368
	Immunisation	85%	371

To further explore those areas of high (rather than very high) satisfaction, crosstabs of participant responses by DHB, ethnicity and age group were performed. The results of this analysis are presented in the following sections, focusing on differences that were 5% or greater. The 5% level was selected to focus the analyses on differences that may have practical significance for pregnancy and parenting education service planners, funders and providers.

9.1.1 Differences between DHB metro regions

ADHB metro region participants were more likely than WDHB participants to agree/strongly agree that they were satisfied with the level of information provided across all the course content areas. The results of the crosstab analysis for early parenting, services and support and immunisation are presented below.

- **Early parenting**
 - 95% of ADHB participants (n=206) and 72% of WDHB participants (n=162) agreed/strongly agreed the classes provided an appropriate level of information.
- **Services and support available in my community**
 - 93% of ADHB participants (n=214) and 77% of WDHB participants (n=167) agreed/strongly agreed the classes provided an appropriate level of information.
- **Immunisation**
 - 89% of ADHB participants (n=204) and 81% of WDHB participants (n=163) agreed/strongly agreed the classes provided an appropriate level of information.

9.1.2 Māori and Pacific participants

Māori and Pacific participants were more likely than NZ European participants to agree that they were satisfied with the level of knowledge provided relating to early parenting and immunisation (Figure 21 and Figure 22).

Figure 21 "The course provided enough information about early parenting"- Māori, Pacific and NZ European participants (ADHB and WDHB metro regions only)

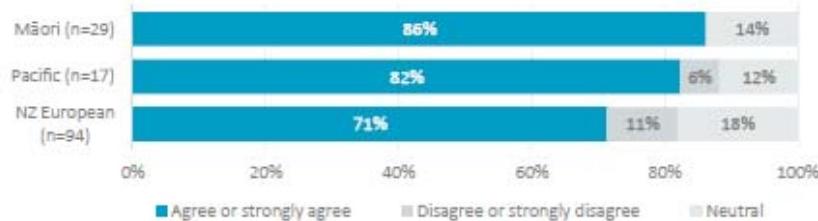


Figure 22 "The course provided enough information about immunisation"- Māori, Pacific and NZ European participants (ADHB and WDHB metro regions only)



Pacific participants were less likely than Māori and NZ European participants to agree that the classes provided enough information about services and support available in their community (Figure 23).

Figure 23 "The course helped me learn more about services and support available in my community"
- Māori, Pacific and NZ European participants (ADHB and WDHB metro regions only)



9.1.3 Asian participants

Compared to NZ European participants, Asian participants were more likely to suggest that enough information was provided across early parenting (91% agree/strongly agree; n=187), services and support available in their community (94% agree/strongly agree; n=185) and immunisation (94% agree/strongly agree; n=188).

9.1.4 Age group differences

Participants aged 35-40+ (n=80) were less likely than those aged 20-34 (n=288) to agree or strongly agree that the classes provided enough information on early parenting and immunisation.

- 79% of those aged 35-40+ and 86% of those aged 20-34 said the classes provided enough information on early parenting.
- 79% of those aged 35-40+ and 87% of those aged 20-34 said the classes provided enough information on immunisation.

9.2 Information and support that participants found the most useful

Information that focus group/interview participants found most useful included content related to:

- Labour and giving birth

- Most participants were first-time mothers, were anxious about the physical processes of labour and giving birth and found the course content related to labour and birth the most helpful.

"I think most first-time mums are worried about the labour. To have... this is what you can kind of expect, and then have it visually put out, so you can see, okay, that's what I'm going to have to handle." (Antenatal class participant)

"Learning about contractions and how they start." (Home visit participant)

- The practical exercises used in some classes e.g. practicing breathing through contractions, were perceived as particularly valuable in supporting their understanding of what would happen.
- Participants also valued that educators were realistic about what could be expected during labour and giving birth.

"She explained this is what people think birth is, and this is what it actually is. I haven't had any children in my family since me, so I had no concept of what bringing into a baby into the world included. So, when she said, it's not like the movies, I'm like, wait, what? She had my attention from there." (Antenatal class participant)

- Breastfeeding

- Participants valued the information and practical exercises used to demonstrate the correct way to breastfeed.

"My favourite was the breastfeeding technique she showed. It was completely different to how I thought you'd actually breastfeed and how tight you have to hold a baby." (Antenatal class participant)



"She actually had a model, a real weight baby, and like passed it around to each person, and then like instructed us how to hold the baby, and how to latch properly." (Antenatal class participant)

- **Navigating the New Zealand health system** (useful to participants who had immigrated to New Zealand).

"It was quite nice to just hear a Kiwi perspective and know the concepts that the hospitals working with before you walk in...this is the culture of giving birth in New Zealand, and to have that set up well." (Antenatal class participant)

- **Post-natal depression**, including its impacts on women's partners, the support available.

9.3 Potential areas where information or support could be expanded

Many focus group and interview participants wanted to receive more information on early parenting, reflecting the findings of the ADHB and WDHB metro region feedback surveys. Areas where participants would have liked more information included:

- **Caring for their baby in the early days after birth.** The previous section highlighted that information on caring for baby was viewed as particularly valuable to class participants. However, this information was not covered in the same depth in all classes. Aspects of baby care that participants in some classes felt could be expanded on included:
 - Breastfeeding¹²
 - Appropriate swaddling
 - Putting clothes on a baby
 - Bathing
 - Burping a baby
 - Establishing a routine
 - Managing baby's sleep

¹² This may reflect the different approaches across the regions and specific classes. WDHB has responded to this need by developing linked breastfeeding classes.

- **Immunisation**

- Participants in three focus groups at three different sites thought their CBEs were hesitant to provide more detail on immunisation due to concerns over participants' different social and political views.

"They didn't really talk about it. I felt like they probably were trying to be diplomatic about it, to say, look, whatever you feel, just trust your instinct. To make those mums who are quite anti [immunisation] to feel okay about it. But I think it would be good to give some information on websites that you could go to learn." (Antenatal class participant)

- Two participants valued this approach as they said it made them feel non-judged. While they did want more information about immunisation, they also liked that immunisation was framed as an option and that they were provided with other options (not immunising or waiting to immunise later on). One of these participants had not yet immunised her child because of this information.
- Although this feedback is based on a small number of participants, it has highlighted the role that antenatal classes and midwives play in influencing parents' decision to immunise. Given the significant public health consequences of low immunisation rates, this may indicate a need to revisit the way in which CBEs communicate information about immunisation.
- **Activities and community groups** that parents could join with their children to help prevent them from feeling isolated and to continue to build their social networks with new parents were also identified as important e.g. Wriggle and Rhyme, Mainly Music.
- **Adapting to life after the baby is born** emerged as a frequent theme that parents would like to know more about. They noted that although labour and childbirth were major challenges, these experiences only lasted a few days at most, whereas the changes to their lives and bodies after the baby was born could last for much longer.
 - Making participants aware of these changes while still promoting pregnancy and birth within the time available is likely to be a challenging for CBEs to try to address.
 - One suggestion made by participants was to get real first-time parents and their babies to visit during the classes and go through what a typical day might be like as a new mother and new parent. This could support new parents' understanding of what life after baby may be like and of the strategies and support available to them.
 - Some mothers engaged in the evaluation post-birth felt that it would have been helpful to have more information about managing the physical and emotional changes that occur after having a baby and an idea of strategies of how to manage these.

10. DELIVERY OF THE COURSE

The survey, focus groups and interviews asked people about their views on the delivery of the course, including the preparation and knowledge of the CBEs:



97% of survey participants agreed or strongly agreed that their educator was well prepared and knowledgeable.
(n=409)

In addition to educators' knowledge of the course content areas, focus group/interview participants valued educators' own personal knowledge and experience of birth.

"She shared some of her personal experiences which helped...knowing that she has gone through it too and she knows what it feels like...helped you to feel better about it all." (Antenatal class participant)

Participants also felt that the educators effectively supported their learning during the classes. In particular, participants valued:

- **Adopting an open-minded and non-judgemental approach**, especially in relation to creating a birth plan and the different options for birth available.
- **Clear and engaging presentation of the key messages**: Educators presented the information in a way that was easy to understand and that kept the class engaged.
- **Opportunities to ask questions**: Participants felt comfortable asking the educator questions during and after the classes and found the answers helpful.

Similarly, the survey data from the ADHB and WDHB metro regions indicated that:

- ✓ 98% agreed/strongly agreed that the educator was easy to understand (n=430)
(Helensville responses also included)
- ✓ 97% agreed/strongly agreed that the educators' answers to their questions were useful (n=428).

The feedback from the home visited survey participants was similar, with all eight participants indicating that the educator was friendly and spoke clearly.

While participants were generally very positive about the facilitation of the classes, participants at one class felt that class time could have been better managed. The large class size also posed challenge in terms of managing discussion time and the ability to cover the key topics in enough depth.

Participants felt that a detailed class schedule would have been useful, as it would enable them to 'park' their questions until the relevant days and reduce the time spent on discussion, as they would know that topics relating to their questions would be covered later.

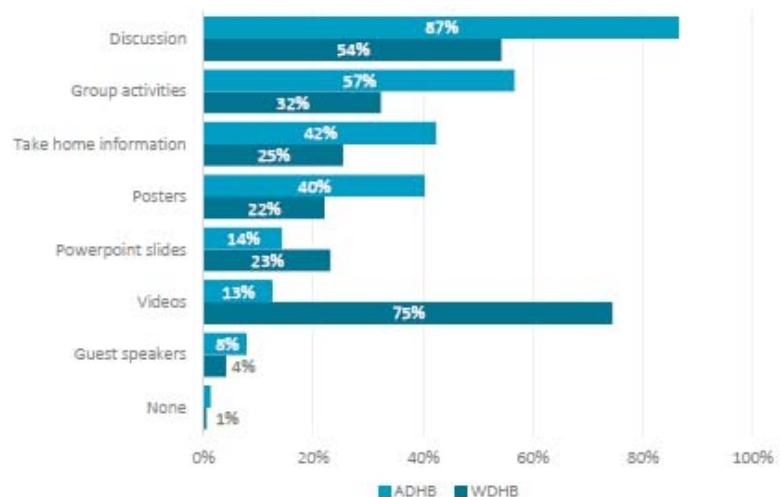
10.1 Usefulness of teaching tools

Discussion and group activities were amongst the top three teaching tools participants found most valuable across both DHBs. This reflects the findings of the participant focus groups/interviews, where many participants identified class discussion and interactive activities and simulations used by educators (such as how to change/bath baby and how to breastfeed) as the most valuable teaching tool.

There were some differences between the ADHB and WDHB metro regions in the perceived value of the other teaching tools used by educators with ADHB participants appearing to value discussion and group activities more than participants from WDHB (Figure 24).

The greatest difference between the DHBs was observed for videos; at ADHB (n=231), only 13% of participants identified videos as a valuable teaching tool, compared to 75% of participants at WDHB (n=173). This reflects the different access to technology across the two DHBs, as many ADHB classes did not have access to the equipment needed to show videos and Power Point slides.

Figure 24 Teaching tools that survey participants found the most valuable, by DHB (ADHB and WDHB metro regions only)

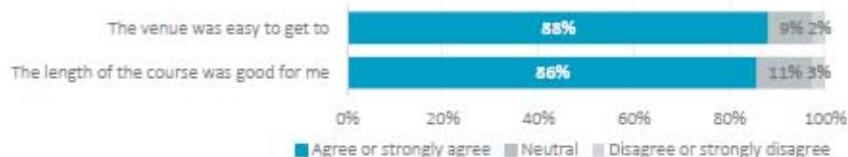


Many focus group/interview participants also highlighted the value of activities that actively encouraged women and their partners/spouses to think through their plans for birth and the life after birth together, such as how household chores would be provided or how to manage visitors once the baby was born. This was viewed as important in both engaging partners/spouses in the class, as well as in getting first-time-parents to think through how they would manage different challenges as a team.

10.2 Course accessibility and suitability: length and venue

Across the ADHB and WDHB metro regions, 86% of participants agreed that the length of the course was good for them and 88% agreed that the venue was easy to get to (n=410; Figure 25).

Figure 25 Participant perceptions of the venue and length of the course (ADHB and WDHB metro regions only)



Some differences in participants' perceptions of the suitability of the venue and the length of the course were observed across different ethnic groups and age groups:

10.2.1 Māori and Pacific participants

Māori participants were more likely than NZ Europeans to agree that the venue was easy to get to and that the length of the course was good for them (Figure 26 and Figure 27).

Pacific participants were slightly less likely than NZ European students to agree that the venue was easy to get to and that the length of the course was good for them.

Figure 26 "The venue was easy to get to"- by ethnic group (ADHB and WDHB metro regions only)



Figure 27 "The length of the course was good for me"- by ethnic group (ADHB and WDHB metro regions only)



10.2.2 Age group differences

- Participants aged 35-40+ were slightly less likely to agree that the venue for the course was easy to get to (83%; n=90) compared to those aged 20-34 (90%; n=314).
- They were also slightly less likely than those aged 20-34 to say that the length of the course was good for them (81% compared to 87%).

10.3 Supporting participants' cultural values

10.3.1 Mainstream classes

Participants in the mainstream, English-speaking classes generally felt that the classes focused on providing evidence-based information and that they were not targeted toward any specific culture. Some participants noted that parts of the information provided were different to what was promoted within their own culture, but felt that the educator was open to different cultural beliefs and promoted participants making their own decisions about which sources of knowledge to draw on.

10.3.2 Kaupapa Māori classes

The Kaupapa Māori classes delivered by Ngati Whatua were perceived as a culturally appropriate service where participants were comfortable with educators running the classes, the environment and the style of teaching and engagement. The inclusion of Te Reo, karakia, waiata, and specific mātauranga Māori with regards to pregnancy, parenting and childbirth are shared during the classes. The kaupapa Māori approach was attractive for Māori and this approach was one of the key reasons for their engagement in the classes. Mandarin classes

Although delivering classes in Mandarin was a key enabler of attendance for the Chinese community, the Mandarin-speaking classes did not support Chinese culture to the same extent as the Kaupapa Māori classes. The Mandarin class educator at ADHB was needed to adhere to the curriculum for the classes, rather than directly promoting Chinese cultural practices. The take-home information was also all in English and the recipes provided in the nutrition portion of the class were not considered to reflect Chinese culture or practices. The educator felt that this was a barrier to engaging Chinese women, particularly new migrants, in class:

"The Chinese community do view those things as quite important; probably more important than the class itself. I do think it is a barrier for them..." (Education Services staff)

It is also important to note that the Mandarin speaking classes at ADHB have been cancelled. The educator was concerned that new migrants would not be able to access the information anywhere else (e.g. online or through pamphlets), as these

resources are not available in their language. She also felt that the cancellation reduced access for a key target group as Auckland has a large Chinese population:

"I do not think cancellation was appropriate. It doesn't give women the opportunity to access education as it was the only free class in ADHB for the Chinese community. It takes away their rights that they had before." (Education Services staff)



11. ENABLERS AND BARRIERS TO ACCESS AND ENGAGEMENT

The following tables identify the key enablers (Table 9) and barriers (Table 10) identified by participants and key stakeholders across the services.

Table 9 Key enablers and benefits across the services

Enabler	Description
Free provision of classes	This was identified by class participants and key stakeholders as a key enabler supporting women and their partners to access the classes.
Positive approach to natural birth	This helped to reduce some of participants' fear and anxiety. This was done particularly well by CBEs delivering services in the rural communities.
Providing realistic information	Educators were honest about the challenges of labour and early parenting. Educators also achieved a good balance between providing realistic information about the challenges of labour and birth and framing it as a normal and positive experience.
Proximity to the class venue	Most participants were able to access classes relatively close to where they live.
Engaging women's partners	CBEs used teaching tools and strategies that engaged women's partners, which encouraged them to continue to attend and participate.
Accessing support in navigating pregnancy and parenting information	Participants felt overwhelmed by the amount of information on the internet and felt that CBEs provided an expert perspective on which information was accurate and reliable.
Online booking system	This system generally worked well and was easy to use.

Table 10 Key barriers and challenges across the services

Barrier	Description
Length of each class	Achieving a class length that would suit all participants is difficult. Even two hours was perceived as a long time to concentrate on teaching by some (particularly for mothers-to-be in the later stages of pregnancy).
Variation in the opportunity to create interactive learning sessions	ADHB and WDHB metro region CBEs did not always have enough time or access to technology to use interactive teaching tools in their classes. The Māori provider and the rural community providers, which delivered more sessions to smaller numbers of participants and had better access to technology, were better

	able to use interactive teaching tools like videos, demonstrations and group activities.
Variation in the opportunity to promote social networks and engagement	In the ADHB and WDHB metro region classes, there was less time and fewer group activities to allow participants to get to know one another. Large class volumes also made this more challenging. Lower class volumes and longer class lengths also meant that CBEs delivering the Kaupapa Māori and rural community classes had more time to promote social interaction between participants. This was also supported by greater use of interactive group activities and CBEs actively supporting coffee groups and engagement via Facebook.
Accessing comfortable learning environments	ADHB and WDHB metro region classes were generally delivered in community halls or hospitals. The venues were perceived as less comfortable than the rural community class venues in terms of amenities (e.g. ADHB and WDHB metro venues were too hot, did not have enough bathrooms or noise could be heard from outside the venue).
Limited use of the Mokopuna Ora website and app	There generally has been low use and engagement with the Mokopuna Ora website and app, with most participants already using other apps and resources that are meeting their needs.
Potential isolation for single mothers	Stakeholders thought that single mothers may feel more isolated during the classes because they did not have a partner to bring with them.
Booking via telephone	Some participants in the ADHB and WDHB regions had difficulties using the telephone booking service.

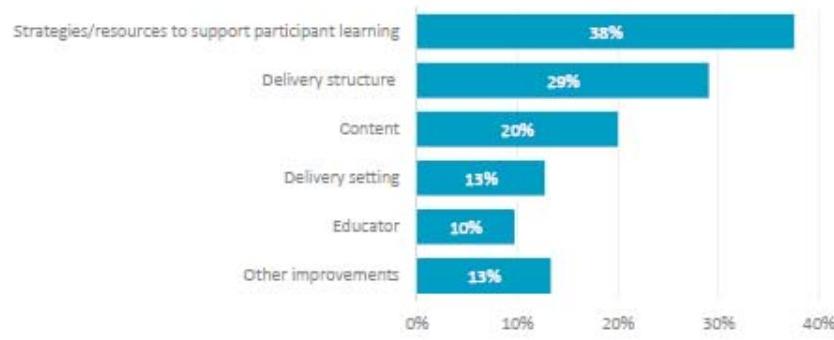


12. PARTICIPANT AND STAKEHOLDER SUGGESTIONS FOR IMPROVEMENT

Survey participants across the ADHB and WDHB metro regions and Warkworth/Wellsford were asked to identify any improvements that could be made to the classes (n=465). Note: this question was not asked in the feedback survey used at Helensville.

Just over two thirds of participants answered the question and provided specific suggestions for improvement (35%; n=465). Participants were most likely to suggest improvements to the strategies and resources used to support participant learning, and least likely to identify improvements related to their educator (Figure 28).

Figure 28 Participant suggestions for improvement



The key ideas for improvements suggested by survey participants are summarised below:

Strategies and resources suggested to support participant learning (38%/62 participants)

- Use a wider variety of teaching tools e.g. videos, PowerPoint slides, guest speakers (31 participants)
- More interactive activities and demonstration (17 participants)

Delivery structure (29%/48 participants)

- Increase the overall length of the course by having longer sessions and/or more sessions (36 participants)
- Change the timing of the classes (8 participants)
- Shorten the length of individual sessions (5 participants)

Course content (20%/33%)

- More information on early parenting, including breastfeeding, sleep routines and swaddling a baby (21 participants)
- More information on the complications that could occur during labour and other birth scenarios e.g. emergency C-sections (9 participants)



Delivery setting (13%/21 participants)

- **Better venue** – warmth and cleanliness were noted as key reasons (13 participants)
- **Providing food**, including healthy food (9 participants)

The educator (10%/16 participants)

- Supporting and providing information for parents wanting to explore options other than natural child birth and breastfeeding (8 participants)
 - At times, this made participants feel uncomfortable and judged for their choices.
- **Being more sensitive to the needs of first-time parents** (3 participants)
 - Some participants felt that the educators' approach did not match the level of knowledge of first time parents or was not sympathetic to the anxieties experienced by new parents.

Other improvements suggested by participants (13%/22 participants) - note only those ideas suggested by two or more participants have been identified here:

- **Providing more opportunities to meet new people** e.g. through more group activities (3 participants)
- **Being able to access the class earlier in their pregnancy** (2 participants)
- **Providing more content from a father's perspective** to help fathers-to-be understand and engage with the classes (2 participants).

12.1 Stakeholder suggestions for improvement

Key ideas for improvements identified from interviews with CBEs and service managers are summarised below:

Supporting CBEs to deliver engaging and interactive classes

- Improve CBE access to technology e.g. access to a projector and internet access so that videos and other visual teaching tools can be used. This was considered important for engaging younger age groups.
- Training for CBEs around using interactive teaching approaches e.g. role play activities.
- Offer more opportunities for social interaction between participants.
- Use a participatory approach to determining course content, where participants can make suggestions about which areas they want the CBE to focus on.

Improved communication between the services and the maternity care sector, particularly to LMCs:

- Relationship building between CBEs and LMCs to support a shared understanding of the types and depth of information being provided
- Increasing sector knowledge to promote and improve access to the classes e.g. how to refer to the service and where mothers and their whānau can go to register for classes

Improving access to pregnancy and parenting education

- Remove being a first-time parent as a criteria for access, so that all mothers who need support can benefit and that other participants can learn from the experience of those who have previously had children.
- Extend the length of classes and/or offer other opportunities to access education to cover more content and to better support participants' learning, particularly around early parenting e.g. postnatal session focusing on early parenting and breastfeeding classes.

Another key suggestion for improvement made was to offer mainstream CBEs an opportunity to attend a Māori providers class and learn more about how a kaupapa Māori approach is delivered, so that they can better support Māori participants.



13. CONCLUSIONS AND KEY CONSIDERATIONS

The Pregnancy and Parenting Services in ADHB and WDHB are providing an important source of information and education for participants. The key value and strengths of the service for participants include:

- Free provision of the classes. This is a key enabler of first-time parents' access to the services
- Feeling better informed about their pregnancy, labour and child birth
- Well informed and engaging educators
- Venue and timing of the classes is generally perceived as accessible.
- The Kaupapa Māori classes are perceived as culturally appropriate and are working well for Māori.
- Delivering classes in Mandarin has previously supported attendance for the Chinese community and particularly new migrants who may have limited English skills.

The evaluation was also designed to understand the reach of the Services, including their role in supporting access for key target groups. The evaluation indicates that:

- Māori, Pacific, 'Other' and younger women are much more likely to receive information via opportunistic education or home visits.
- Asian women are most likely to access education through classes than other ethnic groups.
- ADHB's approach to engaging key target groups with the support of local community providers is effective, with increases in Māori, Pacific and Asian participation observed for ADHB since 2015.
- Opportunistic education and home visits appear to be particularly valuable for engaging the key target groups in the pregnancy and parenting information.

The evaluation also sought to identify the DHBs' progress toward reaching 30% of mothers in key target groups as well as 30% coverage for the total population, as set out by the new MoH contract and associated model. Overall, the data indicated that when group education classes are considered:

- WDHB is achieving the target for Asian women. WDHB is also reaching 19% of Pacific women.
- ADHB is not achieving the target for Māori, Pacific or Asian women, however participation of these groups in classes has increased over time. ADHB also but has a high proportion of 'Other' women being reached, indicating that the service is reaching women from a diverse range of backgrounds.
- WDHB classes are reaching 30% of the total population. ADHB classes achieve the 30% target when all services are considered (classes, opportunistic education and home visits). Reach for the classes alone is 9%.

The differences between DHBs in terms of reach for key target ethnic groups may partially reflect differences in maternal demographics; ADHB as a higher number of Pacific and Asian women giving birth than WDHB, while WDHB has a higher number of Māori and "Other" women giving birth. This finding highlights the challenge for DHBs of expanding their reach to key target groups and the importance of appropriate

resourcing to ensure that DHBs are able to meet target group demand for services in their region.

The evaluation also sought to identify if the Services meet the needs of the new parents, especially the needs of teens, Māori, Pacific, Asian and migrant women. The feedback from the evaluation suggests that the Services are generally meeting the needs of Māori, Pacific and Asian people attending the classes. Attendance rates however indicate that the engagement of the target groups in the classes could be increased. This could be supported through increasing the availability of Kaupapa Māori classes across the DHB regions. Developing a Pacific specific class and/or provider may also be beneficial to supporting engagement with Pasifika.

A key gap in the current data and the reach of the Services relates to teens, as data only identifies those who are 20 or under. At the time of the evaluation ADHB was engaging with a provider to address this gap, however the provider did not deliver any classes as they struggled to engage teens to participate. The literature also highlights the challenges of meeting the needs of teens who often feel isolated attending generic group classes.¹³ Continuing to engage a youth specific provider would appear to be important and valuable in supporting the DHBs in reaching teens and their families.

The engagement of Ngati Whatua and Health Star Pacific by ADHB also appears to have supported the service in being responsive to the needs of different groups and communities. Building on this approach is an important step in reaching out to communities and target groups in a way that reflects their needs and contexts.

The implementation of other services is another key strength of the ADHB approach in terms of reaching the key target groups. The use of opportunistic education was particularly important for reaching the key target groups. While this aspect of the Service was more challenging to evaluate in terms of outcomes, it would be useful for the Service to consider collecting detailed information on the types of information being asked for and/or provided during these opportunities for education. This could support the development of additional resources, and perhaps even links on the Mokopuna Ora website and app that could be shared to further reinforce the opportunity for learning.

The engagement of the Services in the evaluation has highlighted the potential for the Services to continue to be implemented as a learning programme that can adapt to the needs of women and their families. The participants and the CBEs identified very similar ideas for improving the Services. Responding to some of these would further support the Services in meeting the needs of some of their key target groups. We would also suggest that additional engagement and/or evaluation would be needed for the approach to engaging teens and new migrants as this is a gap in this evaluation.

¹³ Pacific Perspectives Ltd. (2013). Maternity care experiences of teen, young, Māori, Pacific and vulnerable mothers at Counties Manukau Health. Wellington: Pacific Perspectives.



13.1 Key considerations

The integration of the evidence provided for this evaluation has identified the following considerations:

- **Continue to use opportunistic approaches to delivering pregnancy and parenting education:** These opportunities have supported reach for key target groups. Given that these sessions can be much shorter than a group education class (5-30 minutes), it will be important to monitor what information is delivered during these sessions. This would contribute to developing resources that could support the value of these sessions, particularly in terms of resources for the key target groups. It is also important for CBEs to continue to use these sessions as also as an opportunity to encourage women to enrol in group education classes.
- **Increase capacity to respond to the needs of Māori:** This could include increasing the availability of Kaupapa Māori classes to help support improved access to culturally appropriate pregnancy and parenting education classes for Māori parents. Additionally, this could also include more education for CBEs delivering mainstream classes in how best to support the needs of Māori participants.
- **Explore ways of providing culturally appropriate pregnancy and parenting education for Pacific parents:** Pacific women's level of participation in Health Star Pacific opportunistic education highlights the value of delivering services that support Pacific women's cultural values. Exploring other ways of reaching Pacific women that embrace these cultural values, such as culturally-appropriate group education classes, has the potential to support improved attendance and engagement with pregnancy and parenting education for Pacific women.
- **Consider different opportunities for increasing engagement of teen parents and migrants with pregnancy and parenting education:** Continuing to work with local providers could help support ADHB and WDHB to improve teen parents' and migrants' access to relevant and appropriate pregnancy and parenting education.
- **Expand opportunities for social interaction and the development of social networks:** A greater focus on social interaction and engagement during classes could help support the development of social networks between participants. This could include:
 - Structuring the delivery of course content around group activities.
 - Set up of the Facebook pages by CBEs before the classes. This would:
 - Provide an opportunity for people to indicate what they would like to learn about before they attend.
 - Support participants' sharing information and getting to know one another earlier on
 - Enable CBEs to provide links to useful resources.



- Set a platform for future engagement and communication for parents and their families.
- Encouraging people to bring food to share could support the social aspect of the classes, particularly where funding for catering may be limited.
- **Review messaging around immunisation:** Classes currently promote national guidelines around the correct way to breastfeed. It is important that the messages delivered around immunisation are also delivered in line with national immunisation guidelines and recommendations.
- **Continue to provide class participants with balanced and evidence-based information about the options available to them for birthing and feeding:** A non-judgemental delivery style where class participants are aware of their options has been key to creating safe and supportive class environments. This approach is important to continue going forward. This may also support parents to feel more prepared if their birth plans change due to complications.
- **Consider reviewing the promotion, content and use of the Mokopuna Ora website and app:** Greater engagement with the app and website could be achieved through earlier promotion of Mokopuna Ora by GPs and midwives. Our brief review of the website and app also suggests that it would benefit from being updated, so that it is similarly interactive to other apps popular with first time parents. Alternatively, it is worth considering partnering with a developer of a major pre-pregnancy app to create an app version relevant to the New Zealand context. This approach would support increased access to information for first-time parents by drawing on the popularity of an existing platform, without losing the New Zealand-specific content that is currently available through Mokopuna Ora.

We have also identified the following key considerations related to ongoing monitoring and evaluation of the Services:

Improving the consistency of monitoring and reporting: This would enable useful comparisons to be made and the tracking of key outcomes over time, which will be particularly important for ongoing evaluation of how well the service is reaching its target groups. This should include a consistent approach to the collection of attendance data by ethnicity and age. Synergia and the DHBs co-developed a survey that could be used to support the collection of attendance data. There should also be a consistent definition of teenage mothers used across the DHBs and services.

- **Capturing the perspectives of women who have received opportunistic education and home visits:** The evaluation has highlighted that a substantial proportion of women are receiving pregnancy and parenting information through opportunistic education. A rapid feedback survey could be developed for this aspect of the service to monitor its value.

Question 42 – Appendix 1 - Auckland District Health Board Register/declaration of Gifts to Staff For 1 July 2017 - 31 June 2018

RECIPIENT	RECIPIENT'S TITLE	WHO FROM	GIFT	ISSUE / REASON FOR POTENTIAL CONFLICT	REASON	DATE	COST	ACTION TAKEN/COMMENTS
Lauren Porten on behalf of ASU General Surgery	Clinical Nurse Specialist	Applied Medical	Sponsorship for Emergency Abdominal Conference		Trade sponsor	07-Jul-17	\$50,000.00	To be retained by the team/service. Approved by Level 2 Manager.
Marion Kindervater, Corporate Business Services	Chief Executive's Personal Assistant	Air New Zealand	High Tea at the Sofitel Auckland		Air NZ Event, in recognition of key contact role for Auckland DHB travel management	27-Jul-17	\$59.00	To be retained by the recipient. Approved by Level 2 Manager
Te Puaruhau, 99 Grafton Road	Puawaitahi Child Protection Service	Spark	Donation of: • Free WiFi installation and broadband connectivity services • 6 x reconditioned tablets • 6 x reconditioned televisions • Free access to age-appropriate Lightbox For use by Auckland DHB, NZ Police and Oranga Tamariki staff, visitors and patients		Spark have agreed to sponsor wifi project	30-Nov-17	\$ 13,724.00	Capex raised.
Chris Hutton, HR	HR Director, Partnering and Management	Simpson Grierson	Lunch for team - 1 Director and 4 Managers @ \$50 per person		Networking event	04-Dec-17	\$200.00	Approved by Level 2 Manager
Fiona Michel	Chief Human Resources Officer	Simpson Grierson	Bottle of champagne		Christmas Gift	15-Dec-17	\$65.00	Approved by Level 2 Manager
Chris Hutton, HR	HR Director, Partnering and Management	Simpson Grierson	Bottle of champagne		Christmas Gift	15-Dec-17	\$50.00	Approved by Level 2 Manager
Chris Hutton, HR	HR Director, Partnering and Management	SBM Legal	Cake for the Team		Christmas Gift	18-Dec-17	\$50.00	Approved by Level 2 Manager
Kirsten Hulme-Moir	Social Worker	Patient	Gold Watch	Value of gift in excess of what might be deemed appropriate for a public servant to accept from a patient or member of the public.	Appreciation of service	18-Dec-17	\$450.00	This was declined by Denise Jane
Vicky Collinge	Starship Community Nurse	Parents of Hermella Merso	Lancome perfume toiletries		Christmas gift	18-Dec-17	\$175.00	Approved by Level 3 Manager
Margaret Dotchin	Chief Nursing Officer	Fashion Uniforms	Bottle of wine and beach bag		Supplied uniforms for midwives and nurses	19-Dec-17	\$20.00	Approved by Level 3 Manager
John Paul Edwards	District Nurse	Patient	Whitcoulls gift voucher		Thank you gift	29-Dec-17	\$50.00	Approved by Level 3 Manager
Anna Rennie (coordinator for competition) Julie Smith, Staff Nurse was the winner of the competition	Nurse Educator, Pediatrics	Barfoot & Thompson	4 night package for 2 to Commonwealth Games in April 2018 on the Gold Coast including flights accommodation, event tickets		5 Star Starship Foundation partner, B&T, want to strengthen links to the hospital, reward staff and create good will	30-Jan-18	\$6,000.00	Approved by Level 2 Manager
Briar McLeod on behalf of NZNIFS Surgical Directorate	Clinical Nurse Specialist, Parenteral Nutrition	Biomed (Jessica Gordon)	NIFS Education & Network Day 2018		Sponsorship NIFS Education & Network Day 2018	02-Feb-18	\$2,000.00	Approved by Level 2 Manager

Briar McLeod on behalf of NZNIFS Surgical Directorate	Clinical Nurse Specialist, Parenteral Nutrition	Nestle Health Science (Eliet Pascale)	NIFS Education & Network Day 2018		Sponsorship NIFS Education & Network Day 2018	14-Mar-18	\$1,000.00	Approved by Level 2 Manager
Briar McLeod on behalf of NZNIFS Surgical Directorate	Clinical Nurse Specialist, Parenteral Nutrition	Fresenius Kabi (Ben Weule)	NIFS Education & Network Day 2018		Sponsorship NIFS Education & Network Day 2018	22-Mar-18	\$4,000.00	Approved by Level 2 Manager
Gil Sewell	Human Resources Director	The Learning Wave	Bottle of Moet and Chandon Champagne		For speaking at a lunch for Auckland L&D Practitioners hosted by The Learning Wave	22-Mar-18	\$60.00	Approved by level 3 Manager
Hilary Lum	Dietitian	A clients family	\$75 Farmers gift card		Gratitude for service	14-May-18	\$75.00	Approved by level 3 Manager
Cathie Lesniak	Operations Manager - Gynaecology	NZ Medical and Scientific Ltd	Donation of Karl Storz Bettocchi hysteroscopes		Removal of Essure from the market	15-May-18	\$7,000.00	Approved by Level 2 Manager
Era Soukhin	Consultant - Anaesthesia	Merck Sharp & Dohme	Registration for workshops: Networks in Anaesthesia and Surgery; Emergency Laparotomy includes accommodation and flights - June 23/24/18		Sponsorship	18-May-18	\$2,000.00	Approved by level 2 Manager.
Judith Catherwood	Director - Long Term Conditions	Mercy Hospice	Bottle of Wine		Leaving gift	23-May-18	\$50.00	Approved by Level 2 Manager
Grace Wu	Nurse Educator, Theatres	Medtronic (Mike McKenzie)	Catering for lunch - Coronary Artery bypass Grafting study day 23/5/18 for 60 nurses from different hospitals in NZ	Documentation in file	Sponsorship	23-May-18	\$600.00	Approved by Level 3 manager
Grace Wu	Nurse Educator, Theatres	Baxter (Ferreira, Grenville)	Catering afternoon tea - Coronary Artery bypass Grafting study day 23/5/18 for 60 nurses from different hospitals in NZ	Documentation in file	Sponsorship	23-May-18	\$400.00	Approved by Level 3 manager
Grace Wu	Nurse Educator, Theatres	J&J (Wendy Bartlett)	Lecture room hiring - Coronary Artery bypass Grafting study day 23/5/18 for 60 nurses from different hospitals in NZ	Documentation in file	Sponsorship	23-May-18	\$500.00	Approved by Level 3 manager
Grace Wu	Nurse Educator, Theatres	Surgical & Infection Prevention (Megan Greggains)	Catering - Coronary Artery bypass Grafting study day 23/5/18 for 60 nurses from different hospitals in NZ	Documentation in file	Sponsorship	23-May-18	\$600.00	Approved by Level 3 manager
Grace Wu	Nurse Educator, Theatres	OBEX (Andrew Westmacott)	Lecture hiring room - Coronary Artery bypass Grafting study day 23/5/18 for 60 nurses from different hospitals in NZ	Documentation in file	Sponsorship	23-May-18	\$800.00	Approved by Level 3 manager
Shayne Tong	Chief Digital Officer, IMS	Deloitte Ltd	Two tickets to Deloitte Winter Gala with APO		Vendor relationship building	23-May-18	\$250.00	Approved by Level 3 Manager
Lydia Baines	Payroll Manager, HR	Business Insights Asia Pacific (BIAP)	Complimentary VIP Invitation to 2018 NZ HR Leadership Summit		Invitation to Leadership Summit	30-May-18	\$990.00	Approved by Level 2 Manager
Vanessa Bowden-Johnson	Collective Employment Agt Implementation Specialist, HR	Business Insights Asia Pacific (BIAP)	Complimentary VIP Invitation to 2018 NZ HR Leadership Summit		Invitation to Leadership Summit	30-May-18	\$990.00	Approved by Level 2 Manager
Barry Snow	Director Adult Medical	Dunedin Hospital	One night accommodation and dinner to attend a botulinum toxin injectors workshop		To support attendance at clinical education workshop	12-Jun-18	\$200.00	Approved by Level 2 Manager

[Return to Question 42](#)

Question 44 – Appendix 1 Sponsorship, Donations, Gifts and Corporate Hospitality Policy

Auckland District
Health Board

STAFF
(Section 6)

Board Policy
Manual

SPONSORSHIP, DONATIONS, GIFTS AND CORPORATE HOSPITALITY

Overview

Document Type	Policy
Function	Corporate Business
Directorates	Auckland DHB Generic
Department(s) affected	All Auckland DHB services
Applicable for which Patients, Clients or Residents?	n/a
Applicable for which Staff?	All Auckland DHB employees
Keywords (not part of title)	
Author – role only	Chief Financial Officer
Owner (see ownership structure)	Chief Executive
Edited by	Corporate Business Manager
Date first published	November 2015
Date last published	November 2015
Review frequency	3 years
Unique Identifier	PP01/STF/098

Introduction

As an agent of the Crown, it is imperative that Auckland District Health Board (Auckland DHB) conducts its business in a way that builds public trust and provides assurance and confidence that public resources are managed lawfully, competently and with integrity.

From time to time Auckland DHB and its representatives receive and accept offers of sponsorship, donations, gifts and corporate hospitality from many sources, including current or potential suppliers, service clubs, trusts, patients and estates. Generally, Auckland DHB and its representatives will not accept offers of sponsorship, donations, gifts and/or corporate hospitality unless there is a clear and justifiable reason to do so and does not compromise Auckland DHB in any way.

Auckland DHB recognises that interactions between its representatives and healthcare related industries (potential sponsors/suppliers) are inevitable. This policy and the '*Sponsor and Donor Interaction with ADHB*' policy define what interactions are appropriate, and provide guidance on how to manage those interactions in a proper and transparent way.

- This policy provides the framework for managing offers of sponsorship, donations, gifts, and corporate hospitality.
- The '*Sponsor and Donor Interaction with ADHB*' policy provides detailed guidance on the appropriateness of specific interactions with sponsors.

Section:	Staff	Issued by:	Chief Financial Officer
File:	Sponsorship Donations Gifts & Hospitality 2015-11-19.docx	Authorised by:	Chief Executive
Classification:	PP01/STF/098	Date Issued:	November 2015

Sponsorship, Donations and Corporate Hospitality

Page: 1 of 10

SPONSORSHIP, DONATIONS, GIFTS AND CORPORATE HOSPITALITY

Overview, Continued

Purpose	This policy defines Auckland DHB requirements when considering and approving (or declining) offers of sponsorship, donations, gifts and corporate hospitality from external parties.
Scope	This policy applies to all representatives (see Definitions) of Auckland DHB. This policy also applies to immediate family of an Auckland DHB representative where the offer (or provision) of sponsorship, donations, gifts and/or corporate hospitality has a clear link with the duties of the representative.

Definitions	Term	Definition
	Corporate Hospitality	Provision of any of the following by a third party: food, beverages, accommodation and entertainment. As a general rule, if the provider is present then it is considered hospitality, if the provider is not present then it should be treated as a gift.
	Donor	A person who gives or contributes money, gifts, hospitality etc to a fund or organisation.
	Donation	The act or an instance of donating something, especially an amount of money.
	ELT	Executive Leadership Team
	Gift	An item offered to a representative in association with their work. A gift may be enduring (e.g. artwork) or consumable (e.g. chocolates) and can range from nominal to significant in value.
	Grant	A sum of money given for a specific purpose e.g. to finance education.
	Inducement	An act of persuasion or influence that is intended to lead someone to do something.
	Koha	An example of the reciprocity which is a common feature of Māori tradition, and often involves the giving of gifts by visitors to a host marae.
	One-up Manager	A representative's direct line manager.
	Probity Register	Otherwise known as a Gift Register.
	Representative	Members of the Auckland DHB Board and the Board's respective Committees, Employees (permanent and fixed-term), Contractors and consultants engaged by Auckland DHB, Seconded personnel, Honorary staff and Volunteers.

'Definitions' continued on next page

Section:	Staff	Issued by:	Chief Financial Officer
File:	Sponsorship Donations Gifts & Hospitality 2015-11-19.docx	Authorised by:	Chief Executive
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Sponsorship, Donations and Corporate Hospitality

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SPONSORSHIP, DONATIONS, GIFTS AND CORPORATE HOSPITALITY

Overview, Continued

Definitions,
continued

Term	Definition
SLT	Senior Leadership Team
Sponsor	Any organisation or individual who offers corporate hospitality a donation, a grant or to pay for, offset or otherwise subsidise events, goods or services (including training, education or research) for Auckland DHB. Includes Donors and Suppliers. <i>Note: The Starship Foundation and the A+ Charitable Trust are not Sponsors in this context.</i>
Sponsorship	Any offer to provide, or fund; travel, accommodation, conference attendance, grants, gifts, donation or corporate hospitality.
Supplier	Any organisation or individual who provides or wishes to provide, goods or services to Auckland DHB.

Associated
documents

Type	Document Titles
Board Policy	<ul style="list-style-type: none"> • Clinical Research - Approval • Conduct Standards • Conflict of Interest • Continuing Professional Education (CPE) Leave & Expenses • Delegated Authority • Delegated Authority Register – Funding Initiatives • Delegated Authority Register – A+ Charitable Trust • Research - Principles • Research - Risk Management • Research – Travel (under development) • Sponsor and Donor Interaction with ADHB
Internal guidelines	<ul style="list-style-type: none"> • Art Committee Guidelines
Starship Children's Health Policy	<ul style="list-style-type: none"> • Trust & Donation Income
External	<ul style="list-style-type: none"> • Office of the Auditor General – Controlling Sensitive Expenditure: Guidelines for public entities • MIAA and MIANZ Code of Practice • State Services Commission – Standards of Integrity and Conduct • US Code of Federal Regulations – US 21 CFR 54. Financial Disclosure by Clinical Investigators

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SPONSORSHIP, DONATIONS, GIFTS AND CORPORATE HOSPITALITY

Principles

Principles

Auckland DHB and its representatives are responsible for their actions and will at all times control expenditure and the use of funds, seeking to ensure that any benefits are in accordance with and do not compromise, Auckland DHB's vision and values and the State Services Standards of Integrity and Conduct.

Representatives must not solicit favours for themselves, family members or others. No one related to the organisation should receive private benefit from any sponsorship.

Auckland DHB must ensure that processes for the acceptance or solicitation of sponsorship, donations, gifts and corporate hospitality are transparent, proper and conducted in a manner that will meet the expectations of stakeholders and the public sector.

Auckland DHB and its representatives will at all times consider:

- The public perception that can result from acceptance (or provision) of sponsorship, donations, gifts and corporate hospitality. Representatives must not accept any offers that would or might reasonably be seen to compromise their integrity.
- Timing and frequency in relationship to receipt of sponsorship, donations, gifts and corporate hospitality. Although offers may be of a limited value, concern could arise should they be offered cumulatively or at a time when it could be seen to influence or reinforce a particular decision. Generally, something offered more than two times per annum would be considered excessive and should be declined.
- The special relationship Auckland DHB has with both the Starship Foundation and the A+ Charitable Trust in the fundraising area. Both organisations have considerable expertise in negotiating sponsorship arrangements.

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SPONSORSHIP, DONATIONS, GIFTS AND CORPORATE HOSPITALITY

Policy Statements

General

This policy ensures that any offer made by a third party to Auckland DHB is carefully reviewed and that any legal, financial or probity risk to Auckland DHB or its representatives in accepting an offer is minimised.

In the event a representative is offered an inducement they must report this to their one-up manager and respective Executive Leadership Team (ELT) member immediately. The one-up manager and/or ELT member may also deem it necessary to inform the Chief Executive.

Representatives must not accept any payments of cash (including cheques) under any circumstances. The only exception to this clause is koha in which case the General Manager Maori Health should be consulted.

Any offers involving the gift, commission or loan of artwork must be referred to the Art Committee for management.

Auckland DHB may desire to solicit sponsorship for the purposes of supporting service needs beyond those funded by normal income streams or contracts. The Sponsor and donor interaction with Auckland DHB policy outlines the parameters for Auckland DHB interaction with sponsors and donors and should be read in conjunction with this policy.

Breaches of this policy will, for individuals, be handled via relevant Human Resources policies.

Circumstances in which offers may be accepted

Auckland DHB's nominal value threshold for the receipt of sponsorship, donations, gifts and/or corporate hospitality is \$50. Any offers below the nominal threshold are not required to be recorded in the Probity Register, however should be approved in advance by the one-up manager.

Gifts and other in kind offers above the nominal threshold of \$50 should generally be declined unless it is impractical to do so (e.g. non-acceptance would offend the giver, anonymous giver). In such circumstances the offer should be recorded in the Probity Register and disposed of using the criteria laid out in this policy.

Offers of sponsorship and donations above the nominal threshold of \$50 may be accepted provided that:

- The offer does not contravene any aspects of this or other organisational policy
- The reason, value, frequency and impact of the offer are all considered prior to acceptance
- The appropriate approvals have been sought prior to acceptance (see Authorisation)

'Circumstances in which offers may be accepted' continued on next page

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SPONSORSHIP, DONATIONS, GIFTS AND CORPORATE HOSPITALITY

Policy Statements, Continued

Circumstances in which offers may be accepted, continued

- The Sponsor and donor interaction with Auckland DHB policy has been referred to
- The offer is recorded in the Probity Register

Offers of sponsorship and donations above the nominal threshold of \$50 may be accepted provided that:

- The offer does not contravene any aspects of this or other organisational policy
- The reason, value, frequency and impact of the offer are all considered prior to acceptance
- The appropriate approvals have been sought prior to acceptance (see Authorisation)
- The Sponsor and donor interaction with Auckland DHB policy has been referred to
- The offer is recorded in the Probity Register

Disposal of accepted sponsorship, donations, gifts, and corporate hospitality

The disposal of accepted sponsorship, donations, gifts and corporate hospitality must be transparent. Auckland DHB may elect to:

- Share the item or value amongst staff or in some instances, allow the recipient to retain for their own personal benefit
- Donate the item or value or auction the items and donate the proceeds to a registered charity
- Approve retention of the item or value if it provides assistance to Auckland DHB in delivering its purpose

Sponsorship, donations, gifts and corporate hospitality received in recognition of services by an individual or group of individuals must be used for the benefit of Auckland DHB as a whole or a group of representatives wherever possible.

Any funding received through sponsorship or donations must be channeled through the A+ Charitable Trust.

Offers received from suppliers should be offset against the price of supplies and services secured for the benefit of the organisation as a whole. Suppliers must provide a declaration stating that acceptance of the offer does not in any way place any obligation on a representative or Auckland DHB. Any funding offered by a supplier must be subject to Procurement approval and be managed through the A+ Charitable Trust.

Acceptance of prizes may also be seen to compromise the integrity of the recipient and Auckland DHB. Prizes awarded to a representative whilst attending an event on the organisation's behalf are to be vetted against this policy and follow the same declaration process. The same applies to free products given as part of purchase incentive schemes.

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SPONSORSHIP, DONATIONS, GIFTS AND CORPORATE HOSPITALITY

Policy Statements, Continued

Circumstances in which offers must be declined

- The following list provides examples of when offers must be declined:
- Offers of cash, cheque, gift vouchers, shares or any other item which may readily be converted to money, irrespective of value
 - The giver, or their organisation, is involved in a procurement process with Auckland DHB or is likely to be affected by a decision relating to a procurement process. Where a representative is involved in a procurement process the Auckland DHB Procurement Policy applies and overrides anything that may be stated to the contrary in this policy
 - Offers that are contrary to any of the principles laid out in this policy
 - The offer is, or could be perceived to be, an inducement

Provision of sponsorship, donations, gifts, and corporate hospitality

As a general rule, Auckland DHB will not fund sponsorship, donations, gifts and/or corporate hospitality for people inside or outside of the organisation. Exceptions to this rule require prior approval of a Level 3 manager or where the value is greater than \$1000, an ELT member.

In instances where Auckland DHB funds the provision of sponsorship, donations, gifts or corporate hospitality in excess of \$50, Corporate Business Services must be notified.

Authorisation

Acceptance of any offer of sponsorship, donations, gifts and corporate hospitality requires management approval, however the level of approval required varies depending on the value of the offer. The following table defines the authorisation thresholds.

Value	Authorised by	Reported to	Recorded
<\$50	In advance by one-up manager	N/A	N/A
>\$50 and:			
<\$1000	Level 3 manager (or above if the Level 3 manager benefits)	Corporate Business Services	Probity Register
<\$7000	Level 2 manager (or above if the Level 2 manager benefits)	Corporate Business Services In advance - Procurement to ensure no conflict	Probity Register
>\$7000	Chief Financial Officer (or above)	Corporate Business Services In advance – Procurement CFO to report to Audit and Finance Committee	Probity Register

Policy Statements, Continued

Section:	Staff	Issued by:	Chief Financial Officer
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SPONSORSHIP, DONATIONS, GIFTS AND CORPORATE HOSPITALITY

Declaration	All offers of sponsorship, donations, gifts and/or corporate hospitality above the nominal threshold of \$50 must be recorded in the Probity Register by Corporate Business Services. Corporate Business Services will vet all declarations to ensure any additional action required is undertaken. Any sponsorship involving overseas travel irrespective of value must be reported to the Internal Audit Manager with an estimate of the value of the sponsorship.
Monitoring	Corporate Business Services is responsible for on-going maintenance and review of the Probity Register and will submit a report to the Chief Financial Officer bi-annually. From time to time the Chief Financial Officer may deem it appropriate to include the Register in their report to the Audit and Finance Committee. Regional Internal Audit will have independent oversight of the Probity Register and may at any time report directly to the Audit and Finance Committee and ELT on compliance with this policy.

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SPONSORSHIP, DONATIONS, GIFTS AND CORPORATE HOSPITALITY

Procedure

Representative Obligations A representative must advise their one-up manager of any offer of sponsorship, donations, gifts or corporate hospitality.

Representatives must ensure that the acceptance of any offer is without any obligation to the providing party.

Representatives should decline an offer unless there is a sound and justifiable business reason for accepting the offer or if declining an offer is impractical (e.g. the giver is anonymous, the giver would be offended).

Representative Disclosure Representatives in receipt of an offer greater than \$50 must disclose to Corporate Business Services for inclusion on the Probity Register.

Representatives involved in the process of purchasing goods or services from an external supplier must disclose details of any offer made by the supplier. This must be disclosed to the representative's Level 3 Manager and relevant Purchasing Officer.

Authorisation criteria Acceptance of any offer above the nominal threshold must be approved by the relevant authority level as defined in the Authorisation section of this policy.

The decision to authorise acceptance of any offer is to be based on:

- Relevance and benefit to the representative, service and/or organisation
- Alignment with the District Strategic Plan and District Annual Plans, Auckland DHB's vision and values, the criteria set out in this policy and if relevant a representative's Performance Plan
- Any additional support (financial or otherwise) that will be incurred by Auckland DHB in accepting the offer
- If relevant, the provision of a Sponsor Declaration

Sponsor Declaration In providing or offering sponsorship, the concerned sponsor must provide a declaration to the authorising manager stating that acceptance of the sponsorship offered does not in any way place an obligation on the representative or Auckland DHB. An exception is to present a conference paper that does not endorse any product or service.

Representative requested sponsorship Representatives intending to approach an external party for sponsorship must obtain prior approval from the relevant authority level as defined in the Authorisation section of this policy. Procurement should also be consulted, irrespective of value, to ensure there is no current or immediate tender process likely.

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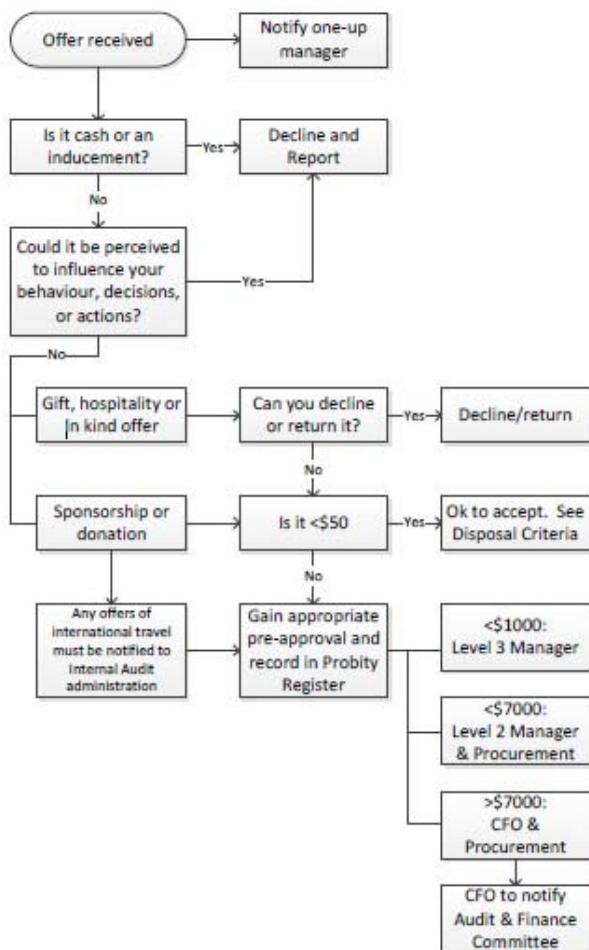
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SPONSORSHIP, DONATIONS, GIFTS AND CORPORATE HOSPITALITY

Procedure, Continued

**Decision-making
flow diagram**



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Question 44 - Appendix 2 Standards of Conduct Policy

Auckland District Health Board

GUIDING PRINCIPLES
(Section 2)

Board Policy Manual

CONDUCT STANDARDS

Overview

This document

This document covers the following topics relating to the Auckland District Health Board Standards Of Conduct.

Topic	See Page
Introduction	2
Shared Responsibilities	3
Customer Supplier Relations	4
Conflicts Of Interest	6
Protection And Use Of Assets	7
Valuing Individual Diversity	9
Compliance - When In Doubt	10

Auckland District Health Board Mission

The Auckland District Health Board will provide New Zealand's finest comprehensive health service through excellence and innovation in patient care, education, research and technology.

He aha te mea nui i tenei ao? Maku e kii atu:

He tangata!

He tangata!

He tangata

What is the greatest treasure on earth?

It is people!

It is people!

It is people!

Message from the Board

We wish to develop Auckland District Health Board as a centre of excellence. The Board's mission statement clearly records our commitment to excellence in delivering high quality Healthcare. To achieve these objectives, our organisation, must constantly seek and implement flexible and innovative ways to achieve our business objectives. Within this environment, we must continue to perform on a high ethical level to maintain our valuable reputation - which is critical to our longer term success.

It is important that each of us clearly understand our responsibilities for conducting ourselves in accordance with the policies and procedures that express the Board's business ethical standards. This "Standards of Conduct" policy summarises these standards to enhance understanding and to enable each of us to properly conduct Board business.

By consistently applying high ethical standards we will continue to support a work environment that is conducive to individual and ADHB success as well as providing a quality service to consumers.

Section:	Guiding Principles	Issued by:	Chief Executive Officer
File:	Conduct.doc	Authorised by:	Auckland District Health Board
Classification:	PP01/PGP/006.DOC	Date issued:	Updated April 2002

Conduct Standards

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CONDUCT - STANDARDS OF**Introduction**

Purpose To guide employees, Members and all representatives of the Board so that their business conduct and decision making is consistent with the Board's ethical standards.

To improve the understanding of the Board's ethical standards among consumers, suppliers and other stakeholders.

Disclosure Throughout this policy situations are identified where employees are required to seek clarification or make certain disclosures.

Unless a higher level of disclosure is specified the principle of "one removed" applies to these situations whereby clarification/disclosure should be achieved by consultation with the individual one senior to the individual seeking clarification or making the disclosure.

Associated documents The table below indicates other documents associated with this policy.

Type	Document Title(s)
Board Policy Manual	<ul style="list-style-type: none"> • Human Resource Principles • Sponsorship: Supplier provided • Conflict of Interest • Expenses – Work Related • Gifts & Gratuities
Delegated Authority	<ul style="list-style-type: none"> • Delegated Authority

Definitions Consumer - any individual or organisation receiving a service from ADHB. i.e. patient/client/resident/customer.

Section:	Guiding Principles	Issued by:	Chief Executive Officer
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CONDUCT STANDARDS

Shared Responsibilities

Individual Accountability

ADHB is committed to delivering quality health services while upholding the highest level of ethical conduct and meeting our responsibilities as a good corporate citizen. In this regard, the Board and all ADHB employees and representatives share certain responsibilities, but individually each is accountable for:

- Adhering to ADHB standards for safe operation of facilities, for providing safe services and products and for protection of the environment.
- Treating all consumers and suppliers in an honest and fair manner.
- Complying with the Board's Bicultural Policy.
- Conducting the Board's business with integrity and operating in compliance with all applicable laws.
- Minimising situations where personal interests are, or appear to be, in conflict with Board interests.
- Safeguarding and properly using Board proprietary information, assets and resources, as well as those of consumers and other organisations entrusted to ADHB.
- Maintaining confidentiality of non public information about ADHB, its employees and its consumers.

Underlying these basic responsibilities is the philosophy that we must maintain respect and dignity for the individual and ensure each person is fairly treated.

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CONDUCT - STANDARDS OF**Customer Supplier Relations****Protecting ADHB's reputation**

ADHB does not seek to gain any advantage through the improper use of business courtesies or other inducements. Good judgment and moderation must be exercised to avoid misinterpretation and adverse effect on the reputation of the Board or its employees. Offering, giving, soliciting or receiving any form of bribe is prohibited.

Accepting Business Courtesies

Generally gifts, favours, entertainment or other inducements may not be accepted by employees from any person or organisation that does or seeks business with, or is a competitor of, the Board except as common courtesies usually associated with customary business practices. (see Gifts & Gratuities)

ADHB recognises that suppliers may wish to provide sponsorship to employees and the Board Policy - Sponsorship:Supplier Provided, explains the circumstances where this is appropriate and the disclosures which should be made.

It is never acceptable to accept a gift in cash or cash equivalent.

Any gift, favour or entertainment received by an employee which could reasonably be perceived by an independent person to influence the judgment of the employees should be disclosed to the employee's service manager.

Giving Business Courtesies

Gifts, favours and entertainment may be given if they:

- Are not excessive in value and cannot be construed as a bribe or payoff.
 - Are not in contravention of applicable law or ethical standards.
- Would appear reasonable if they were subject to independent scrutiny

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CONDUCT STANDARDS**Customer Supplier Relations, Continued****Business
Inducements**

Customer rebates, discounts, credits and allowances are customary business inducements, but careful attention is needed to avoid illegal or unethical payments and to ensure compliance with tax regulations.

Generally, there are few occasions when it would be appropriate to offer a business inducement to a District Health Board purchaser organisation. Any such business inducements must be reasonable in value, competitively justified, properly documented and made to the business entity to whom the invoice was made/issued.

They should not be made to individual officers, employees or agents of such entity or to a related business entity.

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CONDUCT STANDARDS

Protection & Use of Assets

Responsibility of Employees

Proper protection and use of Board assets, including proprietary information, is a fundamental responsibility of each employee.

Employees must comply with site security programmes to safeguard physical property and other assets against unauthorised use or removal, as well as against loss by criminal act or breach of trust.

Employees also have a responsibility to take action to minimise waste or inefficiency.

Internal Controls

The Board has established accounting control standards and procedures to ensure that assets are protected and properly used and that financial records and reports are accurate and reliable. Employees share the responsibility for maintaining and complying with required internal controls and advising an appropriate level of management of any breaches of internal control procedures.

Financial Reporting Integrity

All Board financial reports, accounting records, revenue reports, expense accounts, time sheets and other documents must accurately and clearly represent the relevant facts or the true nature of a transaction. Improper or fraudulent accounting, documentation or financial reporting are contrary to Board policy and may also be in violation of applicable laws. Intentional accounting misclassifications (e.g., cost versus capital) and improperly accelerating or deferring expenses or revenues would be examples of unacceptable reporting practices.

Electronic Information

Board data transmitted and/or stored electronically are assets requiring unique protection. Each data user throughout the Board is responsible for compliance with Information Systems standards and related procedures.

Continued on next page

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Conduct Standards

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CONDUCT - STANDARDS OF**Protection & Use of Assets, Continued****Travel and Entertainment**

Travel and entertainment should be consistent with the needs of the Service. The Board's intent is that an employee neither lose nor gain financially as a result of business travel and entertainment. Employees are expected to spend the Board's money carefully and will only be reimbursed for actual expenditure.

Employees who approve travel and entertainment expense reports are responsible for the propriety and reasonableness of expenditures, for ensuring that expense reports are submitted promptly and that receipts and explanations properly support reported expenses.

There is an onus on all employees to ensure expenditure is not extravagant and would most likely be considered reasonable if it were subject to independent scrutiny.

Strategic Information

Confidential ADHB information (including business strategies, pending contracts or financial projections) may not be given or released, without proper authority, to anyone not employed by the Board, or to an employee who has no need for such information.

Non public information obtained as a consequence of ADHB employment (including information about consumers and employees, suppliers or competitors, real estate acquisitions, research activities, proposed acquisitions or divestitures) may not be used for the personal advantage of the employee or of anyone as a result of association with the employee.

Competitive Intelligence

While collecting data on our competitors, we should utilise all legitimate resources, but avoid those actions which are illegal, unethical or which could cause embarrassment to Auckland District Health Board.

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CONDUCT STANDARDS

Valuing Individual Diversity

Human Resource Principles

The Board policy “Human Resource Principles” outlines the guidelines and principles under which other Human Resource policies have been developed.

Respect of Individuals Rights

In the conduct of Board business, the rights and cultural differences of individuals should be respected.

Unlawful Discrimination

Unlawful Discrimination on the basis of any of the following will not be tolerated:

- Sex
- Marital Status
- Religious Belief
- Ethical Belief
- Colour
- Race
- Ethnic or National Origin
- Disability
- Age
- Political opinion
- Employment Status
- Family Status
- Sexual orientation

Harassment

Harassment of any type will not be tolerated.

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Conduct Standards

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CONDUCT - STANDARDS OF**Compliance – When in Doubt****Seek Clarification**

As a condition of employment with ADHB, employees are expected to comply with the Board's standards of business conduct, policies and procedures. When in doubt, employees have the responsibility to seek clarification from their management or, if necessary, from the Legal Counsel, Quality and Safety Manager or Internal Auditor. Violations of the ADHB standards of conduct are grounds for disciplinary action up to and including dismissal and legal prosecution.

Reporting Abuse

All employees benefit from an atmosphere of good ethical conduct. Unethical conduct could seriously damage the reputation of the Board and all employees.

Employees who are aware of suspected misconduct, fraud, abuse of ADHB assets or other violations of Board Policy are responsible for reporting such matters to an appropriate level of management or, if they prefer, to the Internal Auditor. Every effort will be made to protect the identity of the reporting employee.

The Internal Auditor can be reached by calling ADHB extension 3760 or 27936. Alternatively, Auditor can be contacted on external number 589 3927.

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Question 44 – Appendix 3 Expenses Personal Work Related

Auckland District
Health Board

STAFF
(Section 6)

Board Policy
Manual

EXPENSES – PERSONAL WORK RELATED

Overview

This Document

This document covers the following topics concerning personal work related expenses.

Topic	See Page
Overview	1
Introduction	2
General	3
Accommodation – Expenses	7
Air Travel Expenses	7
Annual Practising Certificates	8
Relocation Expenses Associated with Recruitment	9
Telephones & Communications	11
Other Work Related Expenses	12
Travellers Cheques & Cash Advances	14
• Process	15
Claiming Reimbursement	16
• Process	17
Location of Claims Forms	18

Section:	Staff	Issued by:	Gen Mgr Human Resources
File:	Expenses Personal Work Related_2015-11-27.docx	Authorised by:	Chief Executive
Classification:	PP01/STF/032	Date Issued:	Reviewed November 2015

Expenses – Personal Work Related

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EXPENSES – PERSONAL WORK RELATED

Introduction

Purpose The purpose of this policy is to provide details of the personal work related expenses that may be approved for payment on behalf of, or reimbursed to, employees.

This policy is intended to apply to all types of personal work related expenditure including those expenses where either the employee approving the expenditure or the employee using the services or goods may be (or seen to be) a private beneficiary of the expenditure. For example this includes Continuing Medical Education (CME) expenditure.

Scope This policy applies to all employees of Auckland District Health Board.

Associated Documents The table below indicates other documents related to work related expenses:

Type	Documents
Board Policies	<ul style="list-style-type: none"> • Conduct Standards • Human Resource Principles • Education, Training & Development • Private Vehicles - Business Use • Travel & Accommodation • Annual Practicing Certificate • Cellphones • Recruitment & Selection
Delegated Authority	<ul style="list-style-type: none"> • Delegated Authority

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EXPENSES – PERSONAL WORK RELATED

General, Continued

Approval

The following rules apply to the approval of claims for personal work related expenses.

- All claims must be supported by original receipts or tax invoices for all amounts (copies of receipts or invoices are not acceptable). Credit card statements must be supported by the original credit slip and/or receipt.
- For amounts of \$50 or over inclusive of GST (other than where the payment has been made outside New Zealand) the receipt/invoice must be a GST receipt/invoice (i.e. a receipt showing a GST registration number.)
- All claims must be authorised by:
- The employees RC Manager, or in the case of RC Managers by their immediate manager, and,
- Any higher authority required by this policy or ADHB Delegated Authority (see [Delegated Authority](#) policy)

No employee may approve their own claim or any claim which results in a personal benefit to themselves.

Manager Discretion

The approving manager has discretion to approve personal work related expense claims only within the parameters outlined in this policy and [Delegated Authority](#) policy

Principle of One Removed

In addition to the requirements specified in this policy in all cases the principle of “one removed” applies (for further details refer to Policy: [Human Resource Principles](#).)

The approving manager should obtain the agreement of their manager if:

- They are unsure of the appropriateness of the expense
- There are no clearly established guidelines for the type of expense in question.

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Expenses – Personal Work Related

EXPENSES – PERSONAL WORK RELATED

General, Continued

Frequency of Major Expenses Claims A major expense is one where the claim is for \$500 or more (inclusive of GST) or where travellers cheques and/or a cash advance have been made to the employee in anticipation of the expense.

The claim with supporting invoices and/or receipts must be submitted:

- Within one month of the date of the expenditure, or
- Within one week of the employee's return to work after the expenditure, (which ever is the later).

Note: Failure to meet these timeframes may result in the claim not being approved.

Frequency of Miscellaneous Expenses Claims Where the claim is not a major expense as defined above claims are to be submitted not more frequently than monthly. However, all claims must be submitted within six months of the date of the expenditure.

Prompt Processing The ADHB will process requests for travellers cheques/cash advances and claims for reimbursement promptly following the receipt of a properly completed and authorised SO12.

Ownership of Goods Goods which are either directly paid for by the ADHB or for which an employee receives reimbursement become the property of ADHB.

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EXPENSES – PERSONAL WORK RELATED

General, Continued

Specific Types of Expense

There are many possible types of personal work related expenses and this policy provides explicit parameters for the more common ones, which are:

- Accommodation
- Air travel
- Annual practicing certificates
- Entertainment
- Fines
- Incidental travel expenses
- Incidental expenses (less than \$50 inclusive of GST)
- Membership of professional organisations
- Relocation expenses as defined in the letter of offer
- Telephones and communications
- Vehicles – Private Vehicles Business Use
- Vehicles – Rental

Reimbursement of Other Types of Expense

Expenses which fall outside the above categories and are not a regular fixed amount reimbursing allowances as defined below may be reimbursed only with:

- The approval of the Service Manager or above, and
- In accordance with the General Policy statements in this section and with [Delegated Authority](#) policy

Regular Fixed Amount Reimbursing Allowances

Regular fixed amount reimbursing allowances are allowances which form part of an individual's employment agreement and are paid to the employee as a fixed amount each pay period. These allowances will be paid through Payroll in the employees regular pay e.g., clothing and shoe allowances etc.

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Expenses – Personal Work Related

EXPENSES – PERSONAL WORK RELATED

Accommodation – Expenses

Accommodation Booking	Where possible all business related accommodation will be pre-planned and purchased through ADHB's preferred supplier arrangement. For further details see Policy – Travel & Accommodation .
Class of Accommodation	<p>The following policy defines the classes of accommodation that may be approved:</p> <ul style="list-style-type: none"> • Accommodation will normally be single standard room • Premium or business class accommodation may be used only if: <ul style="list-style-type: none"> – General Manager approval is obtained, and – The accommodation is an integral part of the reason for the travel (e.g. A conference held in a hotel) and a significant discount is available, or – No other suitable accommodation is reasonably available.

Air Travel Expenses

Air Travel Booking	Where possible, all business related air travel will be pre-planned and purchased through ADHB's preferred supplier arrangement. For further details about air travel expenses refer to Policy - Travel & Accommodation
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EXPENSES – PERSONAL WORK RELATED

Annual Practising Certificates

Introduction

Most health professionals are required by law to hold a Practising Certificate (PC) which is renewable annually.

Payment

ADHB will pay the cost of any PC which is legally required by an employee to carry out the duties for which the ADHB employs them except that:

- Part time employees will receive only prorated reimbursement on the basis of the hours they work for the ADHB, unless the employee shows that ADHB is their sole employer.
- ADHB will not reimburse any portion of the cost of a PC that another employer or organisation has already paid or reimbursement.

Refer to ADHB Policy

See Policy - [Annual Practicing Certificate](#)

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Expenses – Personal Work Related

EXPENSES – PERSONAL WORK RELATED

Relocation Expenses Associated with Recruitment

Introduction It will not always be necessary to offer a reimbursement of relocation expenses. However, where it is offered the cost and nature of any proposed relocation expenses are to be considered as part of the total recruitment cost and employment package prior to a decision to appoint being made.

This policy has been developed to clarify the guiding principles and financial implications associated with relocation costs.

Recruitment Policy This section must be read in close conjunction with Policy: [Recruitment & Selection](#).

The Recruiting Manager is the employee principally responsible for ensuring all recruiting decisions are made within the limits set by this policy.

Approval Relocation expenses will be paid only with the advance approval of the Recruitment & Retention Manager who has responsibility for the ADHB relocation budget.

Approval must be sought through the Staff Appointment Form prior to any offer being made to the candidate.

Value The relocation offer value agreed is inclusive of flights, accommodation and moving personal effects. Maximum values will not be exceeded unless prior approval is given by the Recruitment & Retention Manager.

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EXPENSES – PERSONAL WORK RELATED

Relocation Expenses Associated with Recruitment, Continued

Accommodation Accommodation will be arranged through the Careers Centre and price will be a consideration in booking accommodation. The cost of accommodation will be paid directly to the supplier.

Accommodation will be booked for a maximum of 28 days. Where accommodation within walking distance to the ADHB site is not possible, it is the responsibility of the employee to arrange suitable transport.

Personnel & Household Effects For the transportation of personal effects the employee is to obtain three quotes, one of which should be a preferred supplier. The removal agent to be used is to be agreed to by the Recruitment & Retention Manager and the employee to achieve best value.

Airfare Travel Air travel for the employee and immediate dependants will be limited to economy class only, on direct flights at the best cost.

Criteria for Eligibility For an individual appointment to be eligible for relocation assistance, the following criteria must be met:

- Applicant is to be employed to a permanent position
- A bond agreement is entered into at the time the employment agreement is established

Payment Payments of relocation expenses will only be made on a reimbursement basis, upon the employee presenting paid original invoices, unless otherwise agreed to in writing by the Recruitment & Retention Manager.

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EXPENSES – PERSONAL WORK RELATED

Relocation Expenses Associated with Recruitment, Continued

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EXPENSES – PERSONAL WORK RELATED

Telephones & Communications

Communication Costs

Normally, communications equipment (e.g. Facsimile machines, cell phones, Internet connections, etc) will, where necessary, be owned or leased by the ADHB and related costs will be invoiced directly to the ADHB from the supplier. Refer also Policy – [Cellphones](#).

Reimbursement of personal expenses incurred from the use of such equipment will be reimbursed only with the approval of the Service Manager or above.

Telephone Rental

When an cell phone is not provided by the ADHB, an employee can claim costs for business related telephone rentals and will be reimbursed in the following manner:

- Where the employee is employed on an individual agreement, the value of any telephone rental will be incorporated in the individuals salary – there will be no separate reimbursement
- Where an employee is employed on a collective agreement reimbursement will only be made where it is necessary for the employee to be regularly contactable outside normal working hours and to a value of no more than the maximum permitted by Inland Revenue Department policy limits.

Hands-Free Cellphone Devices

ADHB will consider requests for hands-free cellphone devices from clinical staff with an immediate on-call availability requirement (that is, employees who are on an after hours on-call roster and who are required to be at the hospital within twenty minutes).

Pre-approval to purchase a hands-free cellphone device is required from the relevant service manager and claims must be made using the claims process outlined in this policy. Employees may claim back the cost of a hands-free cellphone device up to a value of \$300.

Other Telephone Costs

All other costs associated with telephone usage (e.g. Toll calls) will be reimbursed if made in accordance with the [General](#) policy regarding expenses.

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EXPENSES – PERSONAL WORK RELATED

Other Work Related Expenses

Entertainment It is recognised that on occasion it is appropriate and beneficial for the ADHB to provide entertainment to employees and/or to individuals met by employees while carrying out their duties.

The nature and value of entertainment provided will be within the guidelines set by the service's General Manager prior to any expenditure being incurred.

Entertainment expenses are to be paid for by the most senior employee present at the entertainment and reimbursed on the approval of that employee's manager.

Fines Employees are personally responsible for any fines (such as for parking or traffic offences) they incur and will not be reimbursed by ADHB.

Incidental Travel Expenses – Meals Meals purchased by and for an employee will be reimbursed on an actual and reasonable basis. Meals other than those purchased by and for the employee will be reimbursed in accordance with the preceding [Entertainment](#) section.

Alcohol related claims will not be reimbursed.

Incidental Travel Expenses – Laundry Where the period of travel is in excess of five days laundry charges will be reimbursed on an actual and reasonable basis.

Incidental Travel Expenses – Toll Calls Where the period of travel is of two nights or more toll calls to home of up to five minutes may be reimbursed on an actual and reasonable basis.

Other private calls are to be paid directly to the hotel at time of checking out.

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EXPENSES – PERSONAL WORK RELATED

Other Work Related Expenses, Continued

Connected Expenses	Connected expenditures must not be separately claimed in order to avoid the need for a higher level of approval.
Incidental Expenses (less than \$50 inclusive of GST)	Business expenses of a value of less than \$50 inclusive of GST, which are not covered by specific guidelines, will be approved at the discretion of the employees RC manager in accordance with the General Policy statements.
Membership of Professional Organisations	<p>ADHB will meet the cost of an employee maintaining membership of a professional organisation where membership is necessary for the proper performance of their duties.</p> <p>Membership expenses not specified in the employees employment agreement are payable only with the approval of the General Manager</p>
Vehicles – Rental	<p>Where possible, all rentals will be pre-planned and purchased through ADHB's preferred supplier contract. For further details refer to Policy: Travel & Accommodation</p> <p>Normally the following classes of Avis/Hertz/Budget vehicle are to be used:</p> <ul style="list-style-type: none"> • Where only one or two people are travelling an economy class X or business group A vehicles (1300cc). • Where three or more people are travelling a business group B vehicles (1600cc). <p>When special circumstances exist such as the number of persons travelling or the distance to be travelled or the amount of equipment to be carried make a smaller vehicle unsuitable a business group C (2000cc) vehicle or a station wagon group F may be rented.</p>
Private Vehicle Business Use	See policy Private Vehicles - Business Use

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EXPENSES – PERSONAL WORK RELATED

Travellers Cheques & Cash Advances

Introduction In some cases, usually associated with travel, it is acceptable to provide an employee with travellers cheques and/or a cash advance for an anticipated work related expense.

Employees are to be encouraged to use their own credit cards and claim subsequent reimbursement if the expenses cannot be paid directly by the ADHB on invoice from the supplier.

This approach helps to both:

- Avoid the security risks associated with handling cash and travellers cheques, and
- Provide an itemised record for the employee to track expenses.

Criteria Generally, travellers cheques and/or a cash advance will only be made where an anticipated work related expense is:

- Of a significant value
- Likely to cause hardship or loss to the employee if the reimbursement process is required to be completed retrospectively
- Not able to be paid for directly by the ADHB on invoice.

Pre-Requisite When making a request for travellers cheques and/or a cash advance the employee will be required to obtain a quote or formal estimate of the expected expense.

Advance Amount Travellers cheques and/or cash advances may be approved up to a limit of 100% of the anticipated (quoted or estimated) value of the expense.

For reasons of security cash advances are to be kept to a minimum and travellers cheques are to be signed by the employee at time of issue.

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EXPENSES – PERSONAL WORK RELATED

Travellers Cheques & Cash Advances, Continued

Approval Advances require the approval of the employees General Manager or above.

Process The table below describes the travellers cheques and cash advance process

Stage	Who	Description
1.	Employee	Expense anticipated and quote, or formal estimate of expense, obtained.
2.	Employee	SO12 Form completed and forwarded to RC Manager with quote/estimate from Stage 1.
3.	RC Manager	<p><u>Form is:</u></p> <ul style="list-style-type: none"> • Checked <ul style="list-style-type: none"> – Employee acknowledgement of debt – Valid/reasonable business expense(s) – Maximum of 100% of total anticipated expense • Approval obtained from the appropriate authority as defined by Delegated Authority policy and this policy.
4.	RC Manager	SO12 forwarded to Accounts Payable.
5.	Finance Department	<p><u>Form forwarded to processing point:</u></p> <ul style="list-style-type: none"> • New Zealand currency and travellers cheques to Service Finance Department • Foreign currency to Accounts Payable.
6.	Processing Point	<p>Request processed and travellers cheques/cash advance issued.</p> <p>Note: The value of the advance or travellers cheques will be held as a debt by the employee to the ADHB in the balance sheet until fully reconciled against subsequent reimbursement or repayment to or by the employee.</p>
7.	Employee	Expense incurred.
8.	Employee	Reimbursement Process initiated

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EXPENSES – PERSONAL WORK RELATED**Claiming Reimbursement**

Reasons for Refusal to Reimburse	Claims will not be considered for reimbursement if they are submitted: <ul style="list-style-type: none"> • Without appropriate original receipts/invoices, or • Without an approving Managers signature (i.e. RC Manager, or higher), or • Authorised by the claimant (i.e. Authorised by themselves) or • Outside of the required timeframe (see Frequency of Claims)
---------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Note: In the exceptional circumstance that an original receipt/invoice is not available payment may be approved by a Service Manager on production of other documentary proof of the expenditure.

Petty Cash	Normally petty cash will not be used for reimbursement of work related expenses.
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Exception:

Finance Managers may make an exception to this rule for incidental expenses in their service (i.e. Expenses of less than \$50 inclusive of GST).

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EXPENSES – PERSONAL WORK RELATED

Claiming Reimbursement, Continued

Process

The table below describes the reimbursement of work related expenses process.

Stage	Who	Description
1.	Employee	Expense incurred and (GST if applicable) receipt/tax invoice obtained.
2.	Employee	Work Related Expense Reimbursement form completed and forwarded to RC Manager. Note: Claims relating to previously issued travellers cheques/cash advances must include unused travellers cheques and employees payment if expense is less than previous cash advance.
3.	RC Manager	<u>Claim form is:</u> <ul style="list-style-type: none"> • Checked <ul style="list-style-type: none"> – GST (if applicable) receipts present and correctly calculated – Valid/reasonable business expense(s) – Unused travellers cheques present – Employee payment present if actual expense less than cash advance – The expense has been correctly coded ie not coded to an employee cost code – Approved as per Delegated Authority and this policy • Approval obtained from the appropriate authority as defined in <u>Delegated Authority</u> policy and this policy
4.	RC Manager	Approved claim form forwarded to Finance Manager for review.
5.	Finance Manager	Forwards claim to Payroll for payment.

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EXPENSES – PERSONAL WORK RELATED

Location of Claims Forms

**Claim Forms
Location**

Intranet:

- Human Resources Website / Forms / Pay
 - Work Related Expenses Form
 - Generic Mileage Claim Form

Network:

- N:/Groups/ Everyone/ Forms/ Payroll/ WRF_ADHB.xls
- N:/Groups/ Everyone/ Forms/ Payroll/ MV_CLAIM.xls
- L or N:/Groups/Everyone/Forms/Finance/CNME Finance Guidelines

Note: When travelling overseas on business or for conferences including CME & CMNE, a Leave Application Form must be completed (available on the HR Intranet site).

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Question 44 – Appendix 4 Human Resources Principles Policy

Auckland District
Health Board

STAFF
(Section 6)

Board Policy
Manual

HUMAN RESOURCE PRINCIPLES

Overview

This Document This document states the following principles under which ADHB manages its human resource.

Topic	See Page
Overview	1
Introduction	2
Definitions	3
One Removed	4
Equal Employment Opportunity	5
Unlawful Discrimination	6
Confidentiality & Privacy	7
Good Employer	8
Performance Management	9
Rewards & Recognition	10

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File:	Human-Resource-Principles_2017-01-28.docx	Owner:	Chief Executive & Endorsed by The Board
Classification:	PP01/STF/011	Date Issued:	January 2017 - reviewed

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HUMAN RESOURCE PRINCIPLES

Introduction

Introduction This document outlines the basic guiding principles under which all other ADHB Human Resource policies have been developed.

They underpin the intent of all HR policies and outline the direction the organisation wishes to take with regards to its relationship with employees, both individually and collectively, and their management both now, and in the future.

Legal Obligations ADHB will comply with all relevant legislation, and in many cases the principles stated are supported by such legislation (and their amendments).

Principally these are:

- Employment Relations Act 2000
- Human Rights Act 1993
- Health & Disability Services Act 2001
- Privacy Act 1993
- Health Information Privacy Code 1994
- Health & Safety in Employment Act 1992
- Holidays Act 1981
- Parental Leave & Employment Protection Act 1987
- Health Practitioners Competence Assurance Act 2003
- State Sector Act 1988

Commitment to Employees However, the overriding message to be highlighted is that ADHB has a true commitment to its employees and its services.

Regardless of the minimum requirements of legislation, ADHB will continue to promote and protect the welfare and management of employees to the mutual benefit of employees, consumers, and the organisation.

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HUMAN RESOURCE PRINCIPLES

Definitions

Introduction

The Human Resource policies are about people, and the management of people. As such, the policies cover a wide range of individuals who fulfill different roles in the organisation.

It is necessary therefore, to ensure that all readers have a common understanding of the references made to the human resources involved in these processes.

Definitions

For the purpose of the Human Resource policies, the following definitions will apply.

Term	Definition
ADHB or the organisation	Auckland District Health Board, and all subsidiary companies and organisations.
Patient	Any individual or organisation receiving a service from, or utilising the services of, ADHB. E.g. Patient, client, resident, guardian and customer
Contractor	An employee of another organisation, or self employed individual, providing an agreed service to ADHB.
Employee	Individual who has entered into an employment relationship with ADHB (as defined in the Employment Relations Act).
Honorary Staff	Unpaid individual providing a requested service under the instruction/authorisation of ADHB (e.g. Honorary Medical Consultants).
Visitor	Visitor to ADHB sites who is NOT a patient, contractor, employee, volunteer, or honorary staff.
Volunteer	Unpaid individual providing a voluntary service under the instruction/authorisation of ADHB (e.g. Volunteer drivers, Red Cross workers, Radio Lollipop).

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HUMAN RESOURCE PRINCIPLES

One Removed

Principle Definition The principle of “one removed” refers to consultation with, or gaining of approval from, an individual one senior to the individual making the HR decision, or taking the HR action.

Intent The intent of this principle is not to erode individual accountability for making HR decisions, or taking HR actions.

The intent of this policy is to ensure all HR decisions and actions, in particular those which are different from established norms, are adequately considered prior to their being taken or implemented.

Application This principle will be applied to any Human Resource situation where decisions are required, and authority is:

- Not clearly defined, or,
- Not specified (i.e. Is not in the Delegated Authorities manual, or Stated in other policies in this document), or,
- Where the decision, or action, being contemplated does not conform to established norms

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HUMAN RESOURCE PRINCIPLES

Equal Employment Opportunity

Principle Definition The principle of equal employment opportunity (EEO) is defined as the elimination of any barrier that may deny a potential or existing employee the opportunity to be equitably considered for employment of their choice and the chance to perform to their maximum.

Equal opportunity in employment is concerned with all aspects of employment.

This includes:

- Recruitment
- Pay and other rewards
- Career development
- Work conditions

Scope

This principle will be practised by all representatives of ADHB in the execution of activities relating to the recruitment and management of employees (or potential employees).

Application

This principle will be applied in the following way(s):

- The philosophy and principles of equal employment opportunity are to be included in every aspect of Human Resource decision making within ADHB.
- ADHB will employ individuals, and progress their individual development, solely on the basis of merit, fairness, and appropriateness.

**EEO vs Unlawful Discrimination.
What is the Difference?**

Unlawful discrimination is a set of legally imposed protections that all employers must comply with.

EEO is a much wider principle that is largely self imposed and defined by ADHB. The intent of EEO is to ensure individual opportunity, whereas unlawful discrimination is more concerned with preventing inappropriate behaviours.

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HUMAN RESOURCE PRINCIPLES

Unlawful Discrimination

What is Unlawful Discrimination?

Unlawful discrimination is any action by the employer, or their representative, which denies an individual benefit, or employment (as offered to other individuals with the same or similar qualifications, experience, and/or skills) due to that individual's:

- Age
- Colour
- Disability
- Employment status
- Ethnic or national origins
- Family status
- Involvement in an employees organisation
- Marital status
- Political opinion
- Race
- Religious or ethical belief
- Sex
- Sexual orientation

Scope

For the purpose of this principle employee may be read as:

- All individuals working under the direction of ADHB (i.e. Employees, volunteers, honorary staff, contractors)
- Prospective employees

Application

This principle will be applied in the following way(s):

- Unlawful discrimination of ANY type is not acceptable and will not be tolerated in the workplace.
- Whilst there are isolated instances where ethnicity may be a genuine consideration, there are never acceptable reasons for applying these criteria in a negative or exclusionary sense.

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HUMAN RESOURCE PRINCIPLES

Confidentiality & Privacy

Principle Definition	Information gained during the course of an employee's work for ADHB is confidential and will not be communicated to other individuals or organisations unless:
	<ul style="list-style-type: none"> • There is adequate cause and reason to support such communication and • The receiving individual/organisation has signed and accepted a formal confidentiality agreement, or • The information is requested under a verified legal document (e.g. Employee authorisation, search warrant, court order, etc.), or • Disclosure is reasonably required for other lawful purpose

Scope	<u>This principle is equally relevant to:</u>
	<ul style="list-style-type: none"> • Communications between Employees (i.e. Employee to employee), and, • Communications between an employee and a third party.

Application	<u>This principle will be applied in the following way(s):</u>
	<ul style="list-style-type: none"> • All employees will have, as a consequence of their employment, a confidentiality agreement with ADHB. • All employees will be aware of, and actively implement, their responsibilities regarding confidentiality of information relating to: <ul style="list-style-type: none"> – Other employees – Consumers – ADHB business or developments

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HUMAN RESOURCE PRINCIPLES

Good Employer

Principle definition A good employer is one who operates human resources policies which:

- Contain provisions generally accepted as necessary for the fair and proper treatment of employees in all aspects of their employment, and
 - Encompass the provisions of the Health & Disability Services Act 2001 and all other relevant legislation
-

Application

This principle will be applied in the following ways:

ADHB will be a good employer and will put in place such systems and programmes as to ensure all employees receive fair and proper treatment in all aspects of their employment.

Section:	Staff	Issuer:	Chief Human Resources Officer
File:	Human-Resource-Principles_2017-01-28.docx	Owner:	Chief Executive & Endorsed by
The Board			
Classification:	PP01/STF/011	Date Issued:	January 2017 - reviewed
Page:	8 of 10		Human Resource Principles

HUMAN RESOURCE PRINCIPLES

Performance Management

Principle Definition Performance management aims to achieve an employment culture which results in a continuously improving standard of both individual and overall organisation performance resulting in enhanced delivery of quality healthcare.

Commitment to Review ADHB is committed to the belief that every employee is, as of right, entitled to have their performance reviewed on a regular basis.

Employees will actively participate in performance management.

Application The principle of performance management will be applied by the development of programmes which:

- Align the performance of individual and teams with ADHB strategic objectives
- Support a philosophy of continuing improvement
- Encourage mutual accountability for success of the process
- Clarify roles and responsibilities
- Set performance targets
- Raise individual and team accountability to meet targets
- Assess achievement against expectations
- Devolve decision making and accountability
- Encourage open and effective communication
- Provide feedback and coaching on performance
- Facilitate ongoing personal development and assist employees with their own career planning
- Ensure poor performance is actively managed
- Recognise improved performance with improved compensation

Process Reference should be made to:

- Performance Management for Managers and Team Leaders
- Performance Management for Staff
- Online Training (via Learning & Development intranet site)

Section:	Staff	Issuer:	Chief Human Resources Officer
File:	Human-Resource-Principles_2017-01-28.docx	Owner:	Chief Executive & Endorsed by The Board
Classification:	PP01/STF/011	Date Issued:	January 2017 - reviewed

HUMAN RESOURCE PRINCIPLES

Rewards & Recognition

Principle Definition ADHB Rewards and Recognition Policy is to provide a consistent organisation-wide process which will enhance its ability to attract, retain and motivate the right people to achieve delivery of quality healthcare.

Scope The primary target of this policy is the management of rewards and recognition for ADHB employees on Individual Employment Agreements (non clinical).

Application The guiding principles are to:

- Have a pay system that facilitates competence and behaviour change and advances business vision, values and strategies
- Utilise reward strategy to create a flexible, performance oriented, team driven organisation
- Achieve a fair distribution of the available remuneration dollars, ensuring that jobs within ADHB are remunerated in an equitable manner
- Ensure that remuneration is competitive with other relevant organisations, to a level which is affordable and meets the workforce needs of ADHB
- Motivate and reward individuals through linking performance to remuneration
- Attract and retain skilled and performance orientated employees
- Provide for regular performance review and development
- Implement a consistent and transparent system which is perceived to be fair and balances the costs to the organisation in relation to where ADHB wants to pay in the market
- Improve management of remuneration costs and budgets.

Process Reference should be made to:

- Reward, Recognition and Performance Management
- High Level Principles and Design

Section:	Staff	Issuer:	Chief Human Resources Officer
File:	Human-Resource-Principles_2017-01-28.docx	Owner:	Chief Executive & Endorsed by
The Board			
Classification:	PP01/STF/011	Date Issued:	January 2017 - reviewed
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[Return to Question 44](#)

Question 68 – Appendix 1

Contractors 2017/2018	
Supplier	Cost 17/18
ACCRUE LIMITED	2,800
ALPHA PERSONNEL RECRUITMENT LIMITED	6,026,331
ANGELA SINCLAIR	14,820
AUCKLAND UNIVERSITY OF TECHNOLOGY	30,000
ENABLE WORK SOLUTIONS LIMITED	200
LEXICON	1,020
MANDER AMBER	7,600
OPERATIONAL EXCELLENCE LIMITED	37,200
POTENTIA LIMITED	194,683
PROJECT PLUS LIMITED	177,161
SKT ENTERPRISES LIMITED	7,360
THE UNIVERSITY OF AUCKLAND	61,817
WAITEMATA DISTRICT HEALTH BOARD	30,228
WHERECAPE LIMITED	133,980
JOINT ANAESTHESIA FACULTY OF AUCKLAND TRUST BOARD	10,360
NELSON MARLBOROUGH RESEARCH EDUCATION TRUST	5,800
LAKES DISTRICT HEALTH BOARD	1,565
TAN EMMA	3,000
KURRIYAN RONAN	1,712
MENZI ESTHER	2,250
TEMPLEMAN JANET L T/A FIDGETY DIGITS	1,582
ZHU NATALEE	1,000
PISARI PIETRO	480

DARRAGH MARGOT	3,498
D'SILVA SIMONA	383
MAC-IN-TOUCH LIMITED	800
ANDY ANDERSON'S INDUSTRIAL SERVICES (2007) LIMITED	16,030
HAYES THOMAS	814
PATIENT MANAGEMENT SERVICES LTD	10,800
SARAH BRONTE DENTAL LIMITED	4,440
MINISTRY OF JUSTICE	38,751
BRAINWAVE TRUST AOTEAROA	316
SHINE FOUNDATION LIMITED	4,800
SARA BENNETT	39,780
POSSIBILITIES UNLIMITED LIMITED	525
BLACKIE TOHIARIKI	4,555
TOHITU INDIGENOUS SOLUTIONS LIMITED	2,261
MILNE ALEX	808
TAIRAWHITI DISTRICT HEALTH	100
SAFE WORK NZ LIMITED	6,000
WILLIAMS AUDREY	1,050
NAMIKI FABIO	2,045
VILIPAAMA JO	1,352
SPORT WAINUIOMATA INCORPORATED	100
MILNE CAMPBELL	188
LONG GEMMA	450
PADDY HUGHES INDEPENDENT MIDWIFE	2,754
TRANSCRIPTIONZ LIMITED	507,485

DIGITYPE LIMITED	397,140
SOUND BUSINESS SYSTEMS LTD	4,846
MADISON RECRUITMENT LIMITED	35,426
CAZNA LOWEN	1,108
KILMISTER BRUCE G	12,042
DUNLEAVY RICHARD	70
BURTE DONALD W	561
FRANKS RONNY	3,448
THELMA FRENCH & ASSOCIATES LIMITED	4,250
STREAT KATIE	1,150
DEPARTMENT OF CORRECTIONS CIE	33,008
DEIRDRE MULLIGAN HOLDINGS LIMITED T/A DMHL CONSULTANCY	19,250
KAYELENE CONSULTANTS LIMITED	30,015
DATABYTE SOFTWARE LIMITED	82,230
MACDONALD BRUCE J	5,850
HEALTH ALLIANCE (FPSC) LIMITED	34,716
MINISTRY OF BUSINESS INNOVATION & EMPLOYMENT	14,325
INSIGHTZ LIMITED	37,106
WALDON KATHRYN	118,373
MILLAR STEVENS LIMITED	132,051
MAP YOUR DIRECTION LIMITED	10,260
ORION HEALTH LIMITED	101,500
HR CENTRAL LIMITED	153,240
ARNOLD CHERYL	8,255
LEE STANBRIDGE AND ASSOCIATES LIMITED	20,328

BROWNE KATE T/A STAYSAFE HANDLING	5,797
EMERGENT & CO LIMITED	72,611
HEALTH ALLIANCE LIMITED	1,050
CODE BLACK LIMITED	11,680
DOBROWOLSKI OLIVIA	4,640
WAIORA PACIFIC LIMITED	20,000
BAGNALL CANDACE	21,400
MANSON LEIGH	65,763
COMMUNIQUE LIMITED	20,900
BUCHANAN ARNOLD LIMITED	250
BAKER DR SIMON	4,125
Bodo Lang Consulting	9,750
ANGELOU ELYSE	5,964
Waitakere Hospital	1,030
KIRSTY JONES COMMUNICATIONS	31,920
DANN JENNIFER	10,690
BODDE ANNEKE	15,975
PROMPT AUCKLAND	2,400
Grand Total	\$ 8,969,524.82

Consultancy 2017/2018	
Supplier	Cost 17/18
4SIGHT CONSULTING LIMITED	3,171
ACCRUE LIMITED	5,600
AD HOC VENTURES LIMITED	147
ADDED INSIGHT LIMITED	3,250
ADVANCED MANAGEMENT SYSTEMS LIMITED	

	878
AFFINITY SERVICES LIMITED	1,200
AHR PROFESSIONAL SERVICES LIMITED	1,980
ALCHEMY LIMITED	1,969
ALDERTON MACKENZIE LIMITED	5,330
ALLAN-DOWNS PAULINE	5,600
ALPHA PERSONNEL RECRUITMENT LIMITED	50,260
ANGELA SINCLAIR	98,612
ANN BONNIE JOHNSTON	5,884
AON NEW ZEALAND	9,100
APPLIED & PROFESSIONAL ETHICS LIMITED	400
AQUAFIRE LIMITED	56,430
ASKRIGHT LIMITED	4,505
AUCKLAND UNISERVICES LIMITED	3,465
AUCKLAND UNIVERSITY OF TECHNOLOGY	80,695
AURECON NEW ZEALAND LIMITED	5,500
AUT ENTERPRISES LIMITED	8,602
BARNETT RICHARD T/A BARNETT CONSULTING	28,400
BECA LIMITED	5,124
BENTLEY & CO LTD	4,287
BLACKBAUD PACIFIC PTY LTD	42,474
BUZZ CHANNEL LTD	43,450
CABIX COMMUNICATIONS LIMITED	2,282
CANTERBURY DHB	61,335
CCS DISABILITY ACTION AUCKLAND INCORPORATED	200
CENTRAL REGION'S TECHNICAL ADVISORY SERVICES LTD T/A CENTRAL TAS LTD	

	29,557
CHANGING MINDS TRUST	1,739
CHILD CANCER FOUNDATION INCORPORATED	37,885
CHUNG ROSEMARY	73,080
CITY EYE SPECIALISTS	7,230
COMPASS GROUP NEW ZEALAND LTD	12,001
COUNTIES MANUKAU DHB	7,640
CRANLEIGH	32,260
D C CONSULTANTS	1,000
DATA SYNTHESIS Ltd T/A MedSyn Software	8,961
DEBRA ELLIS & ASSOCIATES LTD	121,905
DELOITTE LIMITED	227,023
DR DOWNEY CONSULTING LIMITED	1,391
Dr Janet Milne	2,560
ELDER-KNIGHT CONSULTING LIMITED	5,000
EMOVARE LIMITED	900
ENABLE WORK SOLUTIONS LIMITED	1,792
ENIGMA SOLUTIONS LTD	2,640
ERNST & YOUNG GROUP LIMITED	184,533
ERNST & YOUNG LAW LIMITED	7,224
FINN DR ELIZABETH	2,735
FUJI XEROX NEW ZEALAND LIMITED	1,383
GEYSER CREATIVE GROUP LIMITED	45,204
GIBSON HAMISH T/A SUPPORT LOGIX	10,275
GKP PSYCHOLOGY LIMITED	630
GLADEYE LIMITED	

	60,000
GRANT THORNTON NEW ZEALAND LIMITED	69,946
Hamish Gibson	4,275
HARDING DR ELIZABETH	815
HEALTH ALLIANCE LTD	2,020
HEALTH LITERACY NZ LIMITED	450
HEALTH QUALITY AND SAFETY COMMISSION	173,704
HEALTHLINK GROUP LIMITED	5,112
HEART BUSINESS CONTINUITY	47,520
HEYWOOD MELISSA	560
HUNTER GROUP LIMITED	4,000
ID LABORATORY LIMITED T/A ID/LAB	9,600
iEXCEL LTD	47,992
INFORMATION LEADERSHIP DESIGN SERVICES LTD	48,689
INTEGRATED PROJECT MANAGEMENT	1,500
INTERNATIONAL ASSOCIATION OF CANCER REGISTRIES	703
JACKSON ENGINEERING ADVISERS LIMITED	10,185
JAE FREW PHOTOGRAPHY & DESIGN LIMITED T/A JAEFREW PHOTOGRAPHER	27,370
JENKINS DION T/A DJ BUSINESS CONSULTANT	46,960
JILL LOMAS MANAGEMENT CONSULTANT	4,910
JULIA STONES & ASSOCIATES LIMITED	700
JULIE SMITH DERMATOLOGY LTD T/A DR JULIE SMITH	3,378
KAHUI TU KAHA LIMITED T/A RAINBOW TICK	9,200
KENSINGTON SWAN LAWYERS	8,599
KLEIN LIMITED	7,890
LEXICON	

	4,980
MACDONALD RACHEL	880
MACMURRAY INSTITUTE LTD	1,296
MAKEREADY LIMITED	2,678
MANDER AMBER	74,775
MARSHALL DAY ACOUSTICS LIMITED	1,226
MATERNITY CONSUMER ENGAGEMENT SERVICES	4,893
MEDIAMINE LIMITED	9,861
MERCER (NZ) LIMITED	12,010
MERRINGTON PRINT MANAGEMENT LIMITED	3,980
MESHNINETY LIMITED	26,950
MEYER ELAINE	8,553
MINISTRY OF HEALTH	213,545
MORE HUMAN LIMITED	4,050
MULQUEEN CONSULTING LIMITED	74,000
NEW ZEALAND DISPUTE RESOLUTION CENTRE	6,522
NS HOTEL SERVICES EDEN LIMITED T/A QUEST ON EDEN	4,134
NSW HEALTH PATHOLOGY	475
ON ARRIVAL NZ LIMITED	4,400
OPERATIONAL EXCELLENCE LIMITED	52,800
PACIFIC INTERNATIONAL TRANSLATIONS (NZ) LTD	270
PANTING ALLAN	10,761
PATERSON RON	10,934
PIDGEON DR GRANT	751
PIVOTEL NEW ZEALAND LIMITED	295
POINT & ASSOCIATES	

	38,622
PRECEPT HEALTH LTD	21,000
PRICEWATERHOUSECOOPERS	64,184
PRICEWATERHOUSECOOPERS CONSULTING (NEW ZEALAND) GP COMPANY	102,177
PROFESSIONAL PROFILES LIMITED	65,700
PROJECT PLUS LIMITED	2,100
PSYCHOGENIX LIMITED	600
RAWDON CHRISTIE COMMUNICATIONS LIMITED	3,100
RETINA SPECIALISTS LIMITED	11,824
RON DICK	1,450
ROV ENTERPRISES LTD	112,393
SANDERS ELIZABETH T/A MAKE TOOLS LLC	254
SHEFFIELD NORTH ISLAND LIMITED	28,780
SKT ENTERPRISES LIMITED	1,020
SLEEP & BREATHING (NZ) LIMITED	522
SOLNET SOLUTIONS LIMITED	17,501
SPARKS INTERACTIVE LIMITED	713
SPIN CREATIVE BRAND & DESIGN	150
SRL DERMATOLOGY LIMITED	3,002
STOKS LIMITED	52,698
STOREY DYLAN J T/A C P DESIGN	425
SUNDERWARE LIMITED T/A LEARNINGWORLD DESIGN	600
SWEETAPPLE IAN R	16,785
TE WAIPUNA PUAWAI MERCY OASIS LIMITED	4,348
TELFER YOUNG	52,805
TENZING LIMITED	

	52,966
THE BOARDROOM PRACTICE LIMITED	20,531
THE FULL SUITE LIMITED	2,990
THE SYSDOC GROUP LIMITED	170,185
THE UNIVERSITY OF AUCKLAND	17,918
THINKPLACE LIMITED T/A THINKPLACE	4,579
TOAST LIMITED	9,370
UDS CONSULTING LIMITED	49,750
UNCOMPLICATE LIMITED	450
VIVID SOLUTIONS LIMITED	1,320
WAITEMATA DISTRICT HEALTH BOARD	22,440
WALKER KING CONSULTING LIMITED	25,897
WESTGRAVE CONSULTING LIMITED	13,950
WHANGANUI DISTRICT HEALTH BOARD	520
WHERECAPE LIMITED	39,300
WILLIAMS SIMON	20,000
WILSON ME T/A CHILD HEALTH CONSULTING	3,766
Grand Total	\$ 3,556,453.28

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Question 145 – Appendix 1

Māori Health Planning and Funding Report – Quarter Four

2016/17

Auckland and Waitemata DHB Performance Scorecard

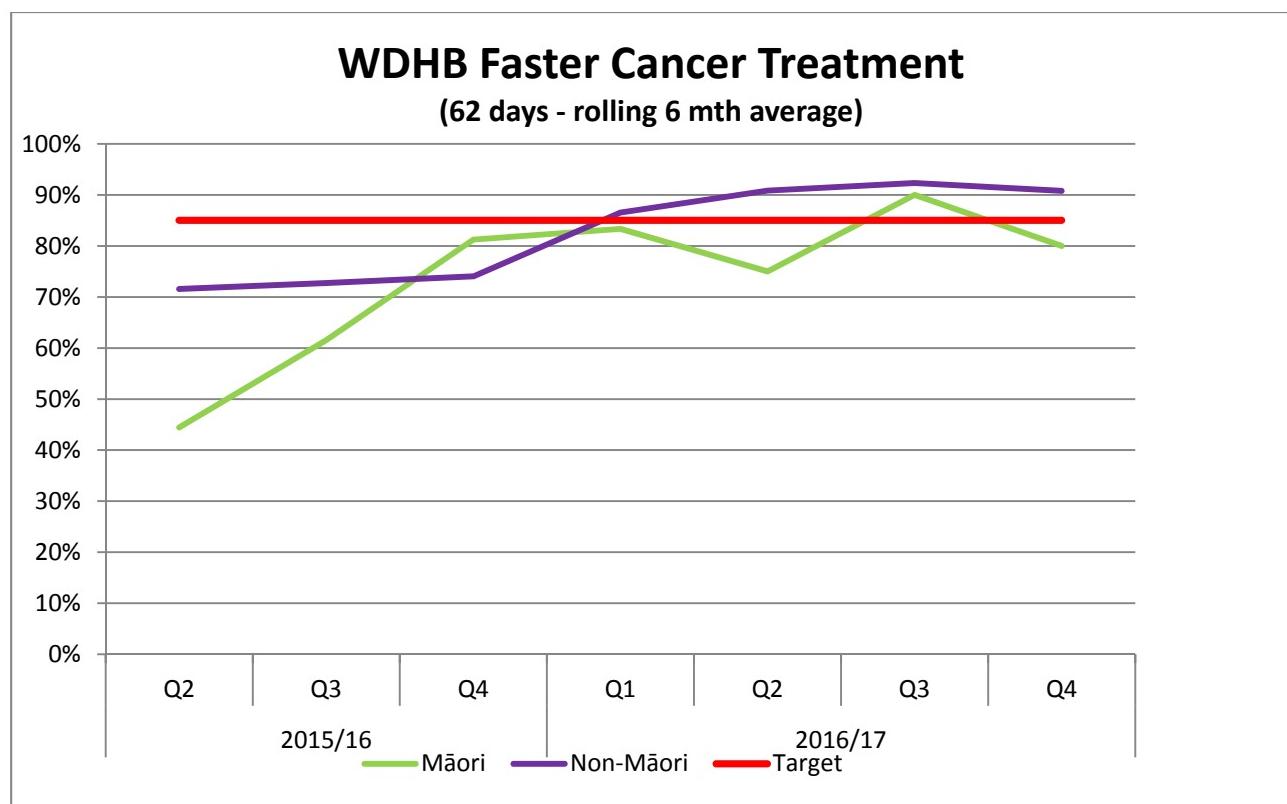
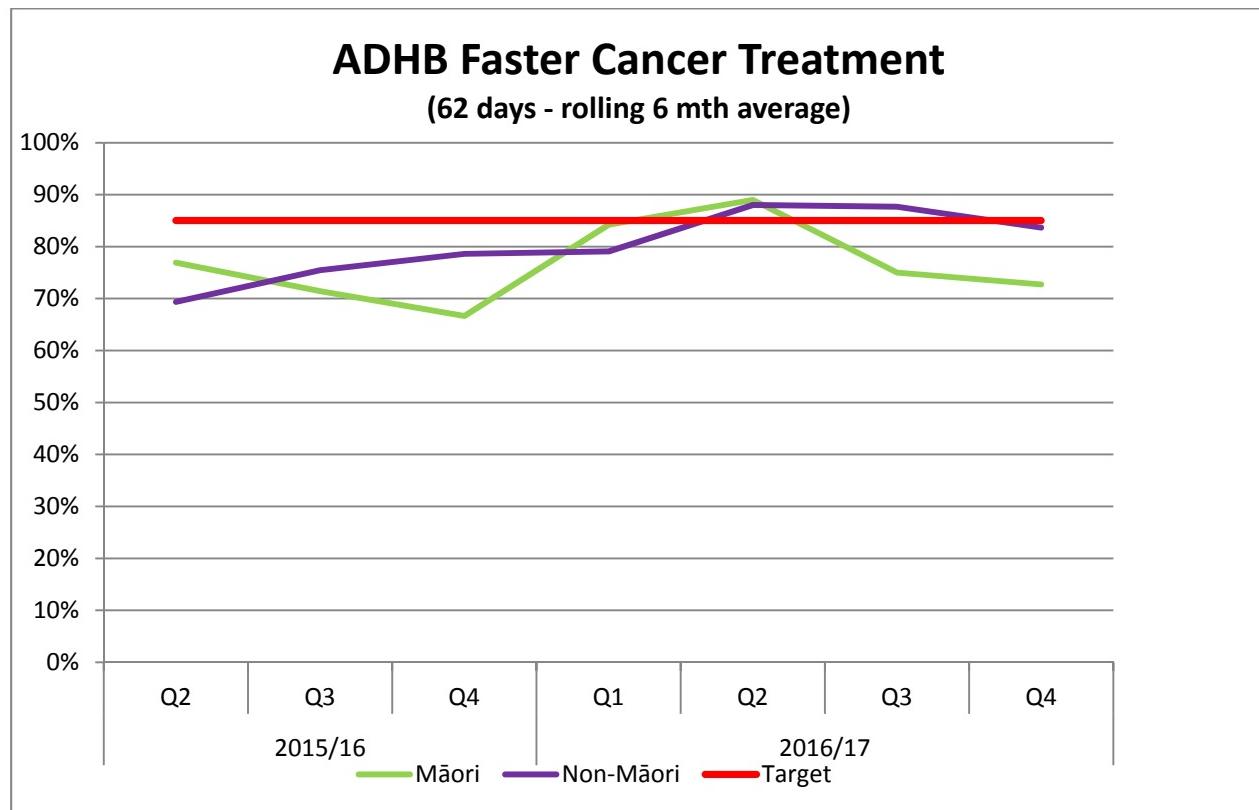
Māori Health Outcome Scorecard

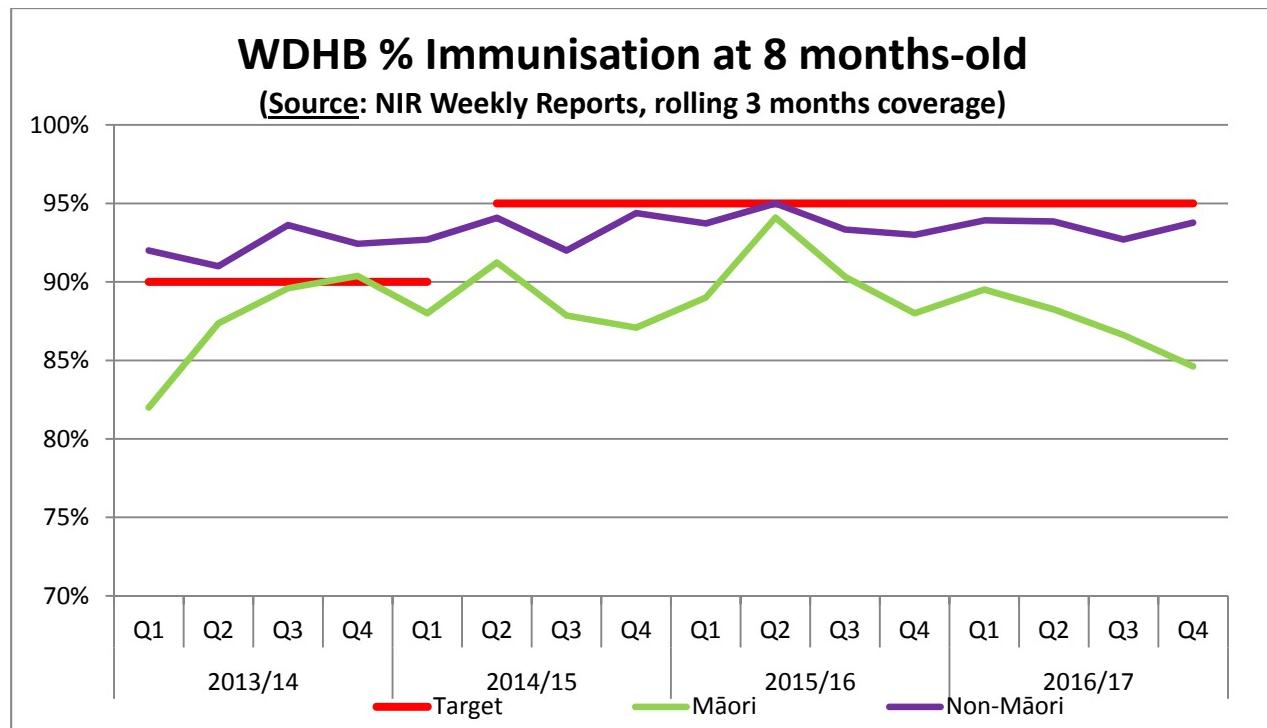
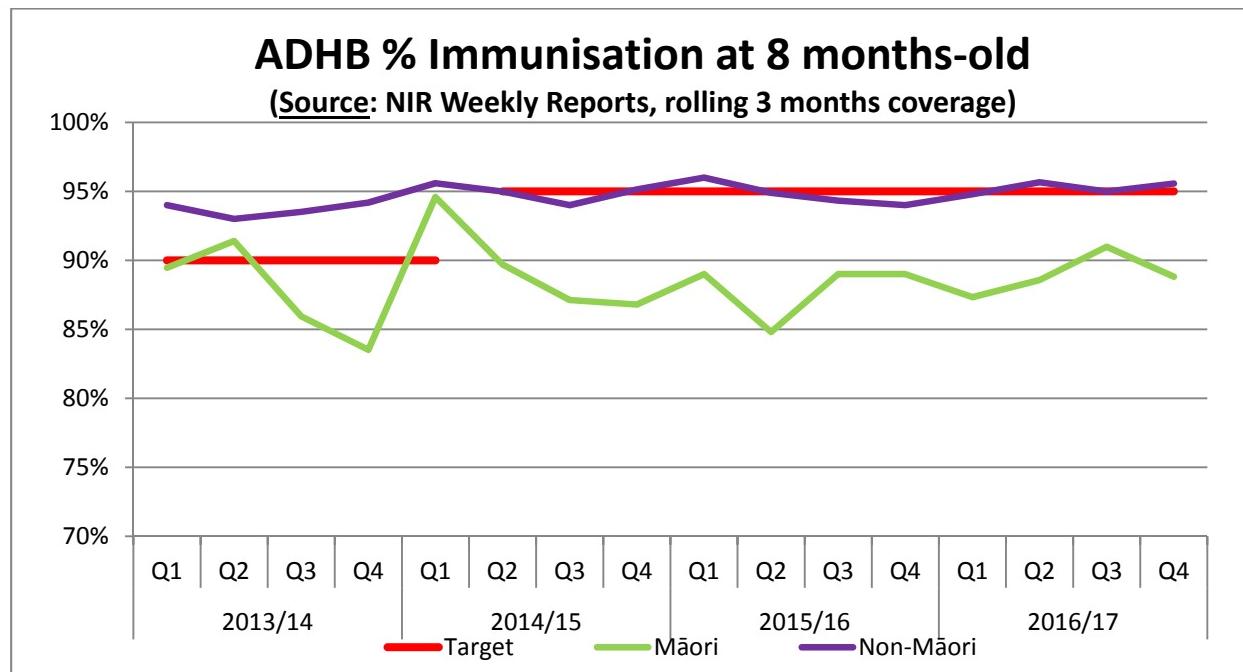
June 2017

2016/17



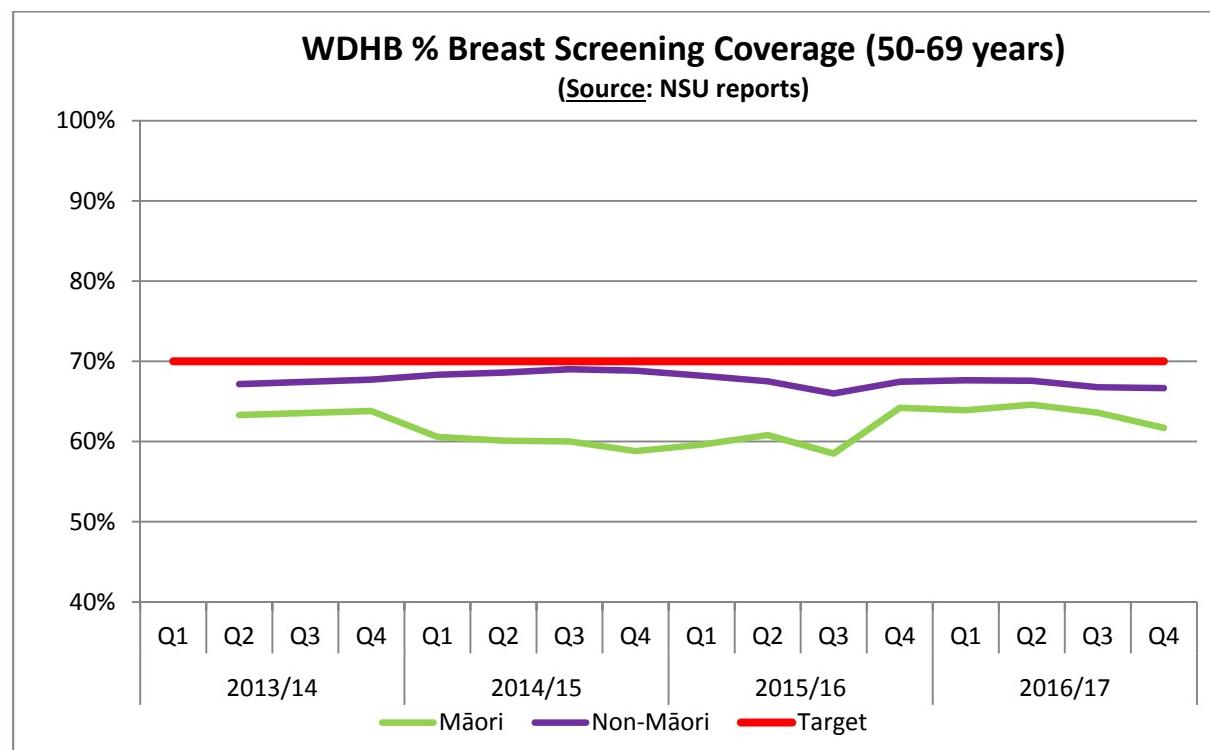
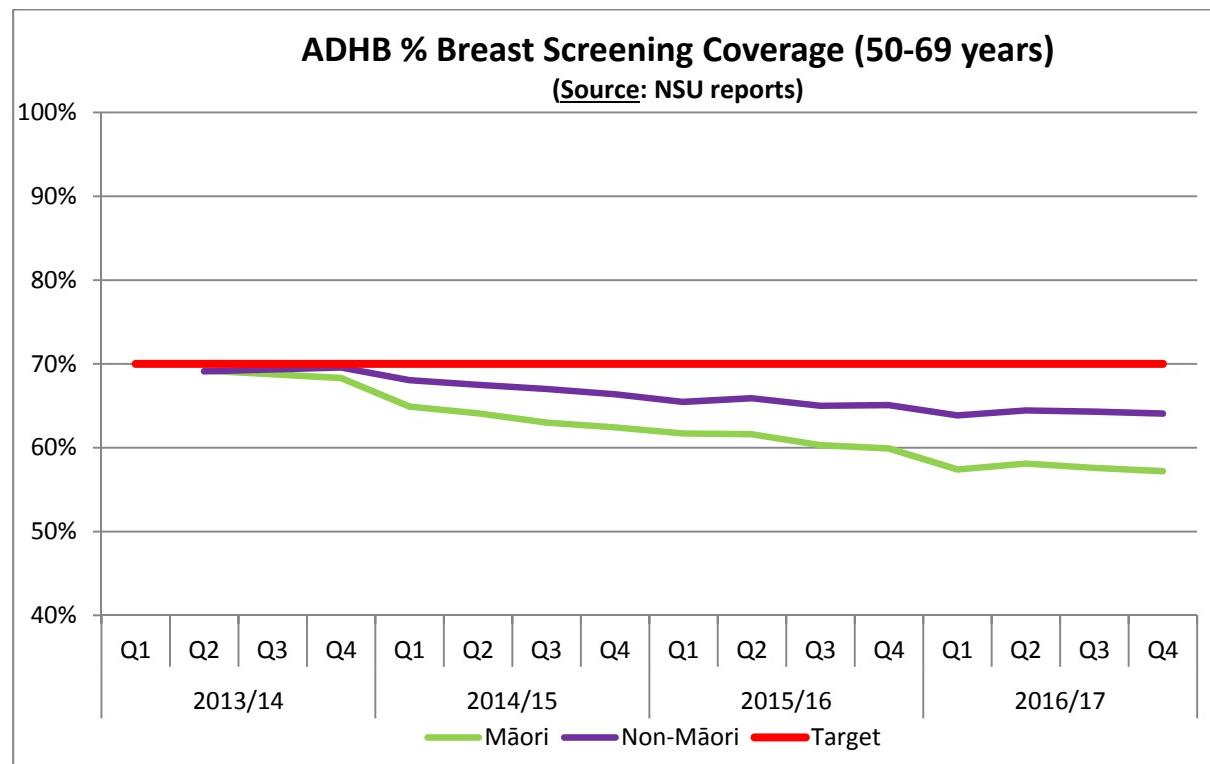
Health Targets - Faster cancer treatment

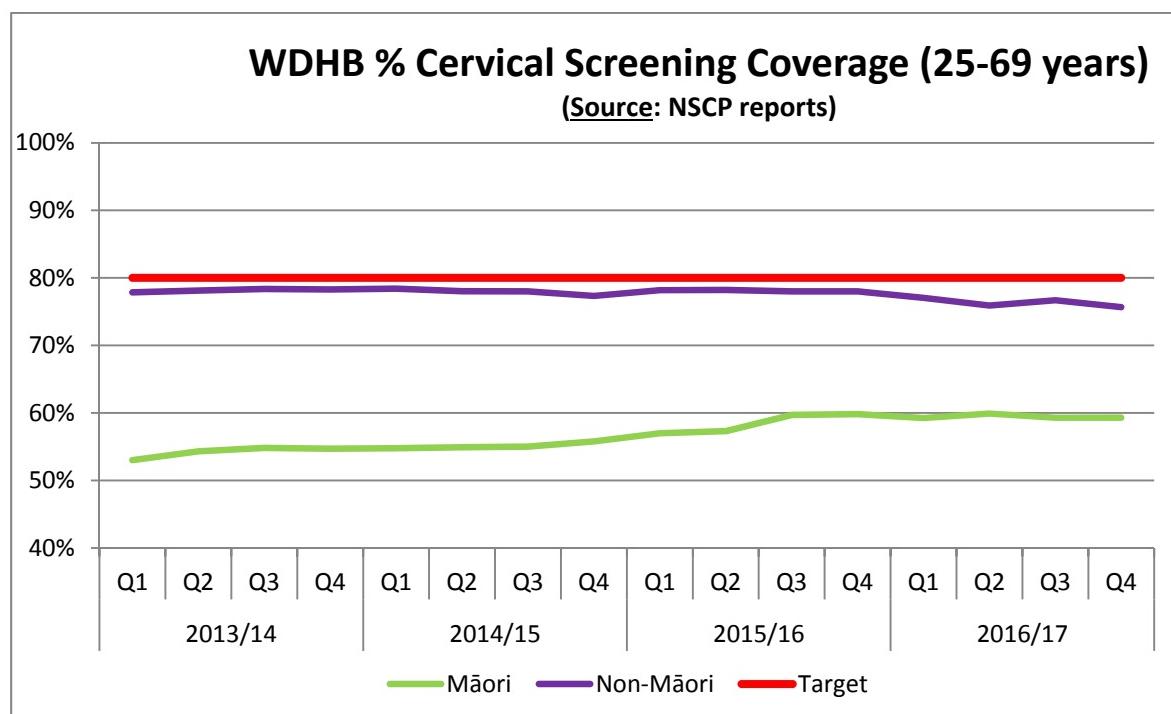
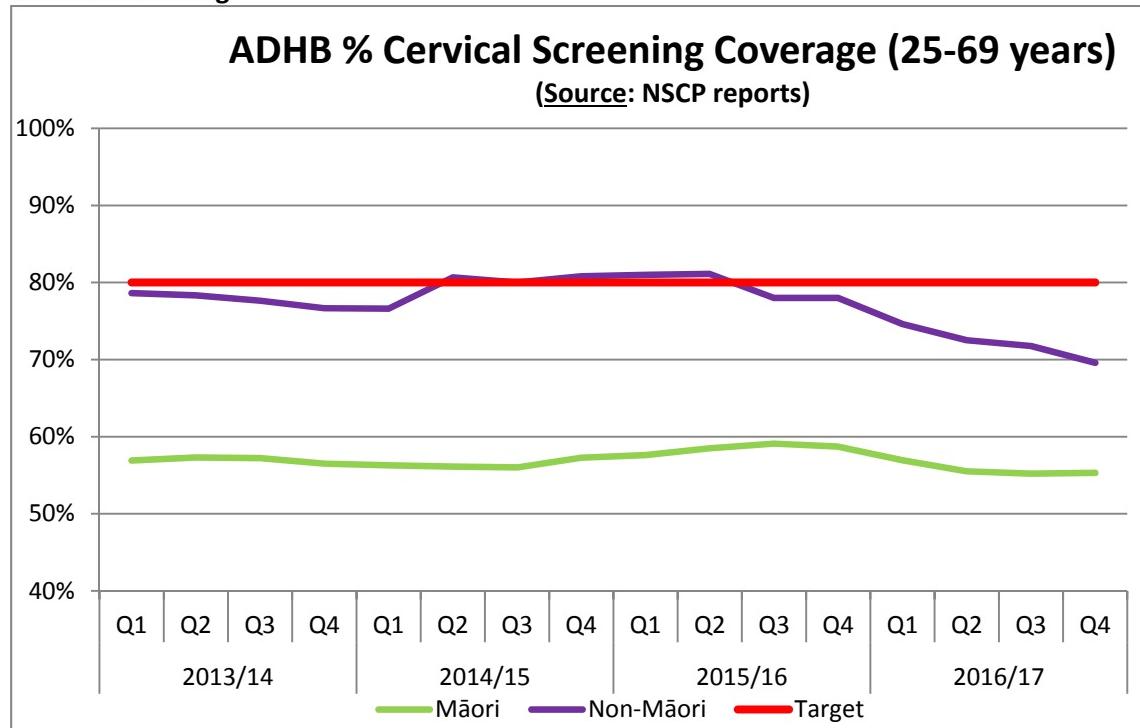


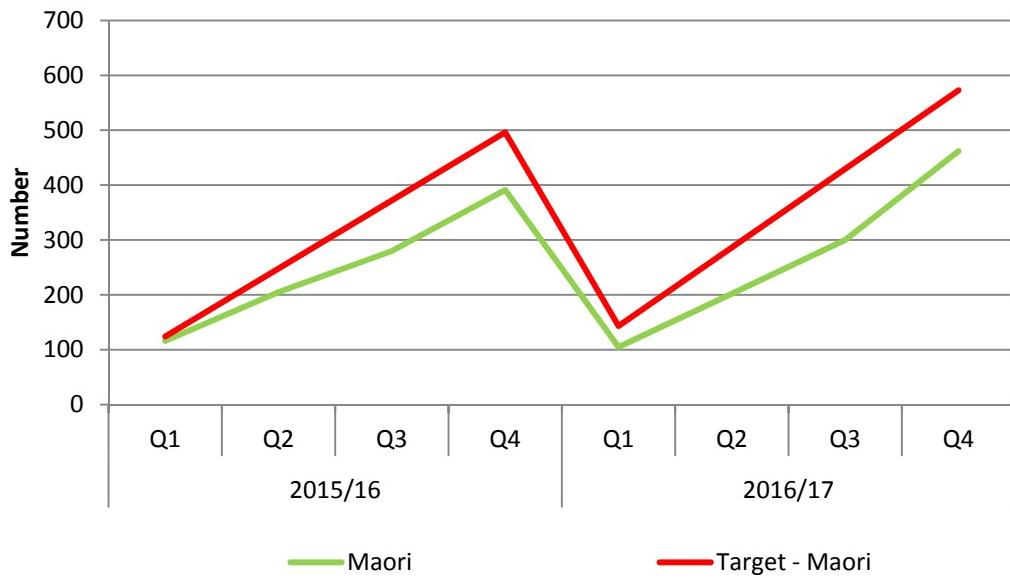
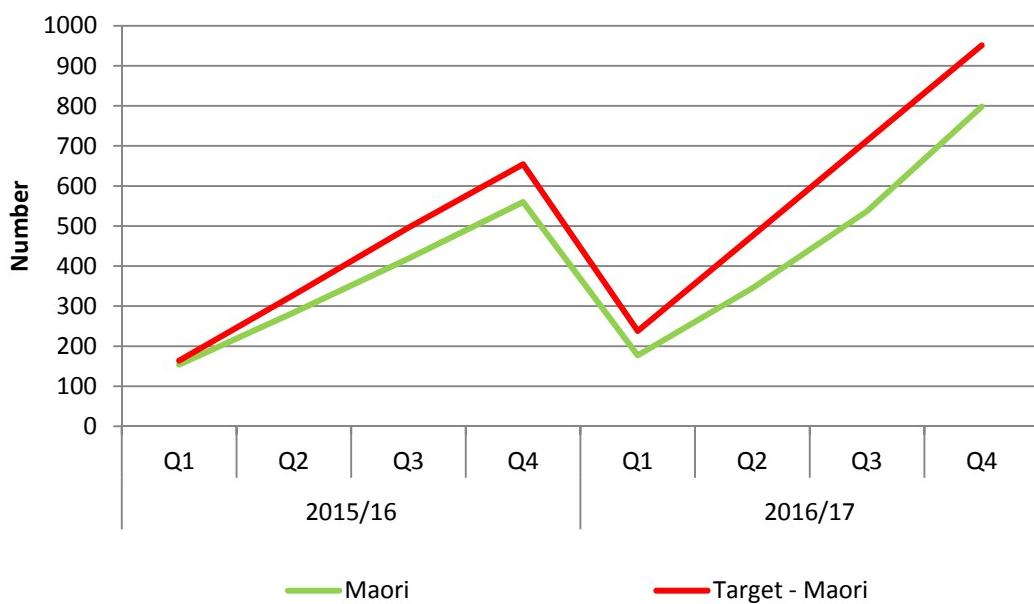
Immunisation

Access

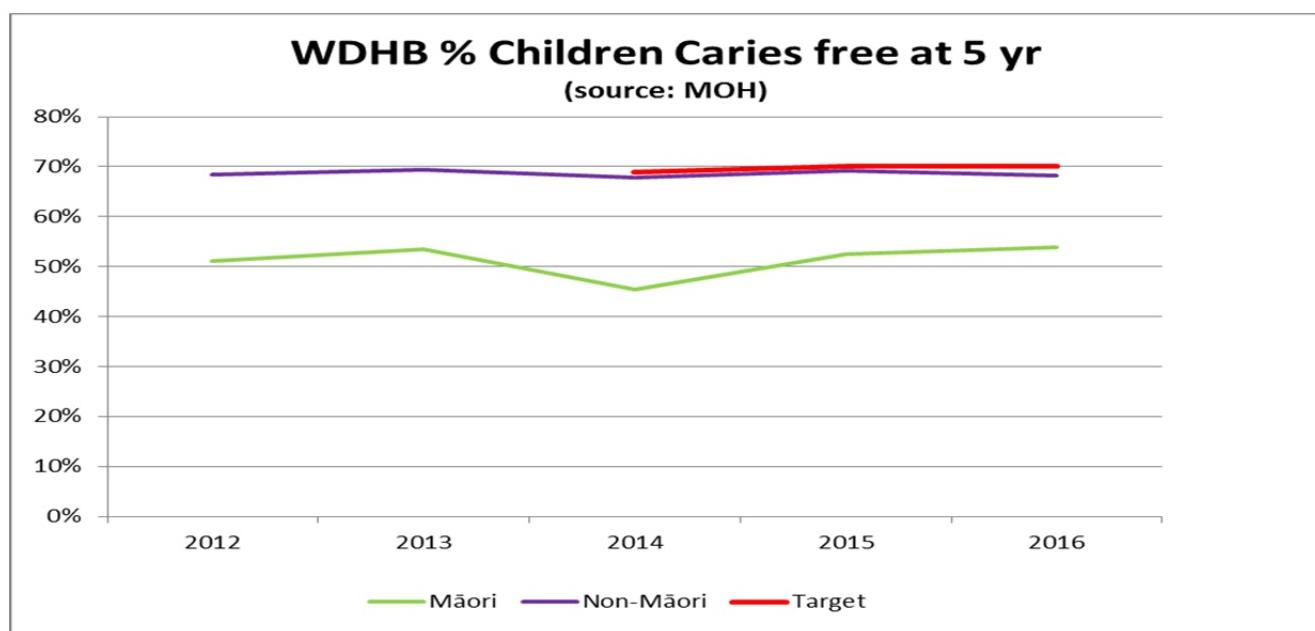
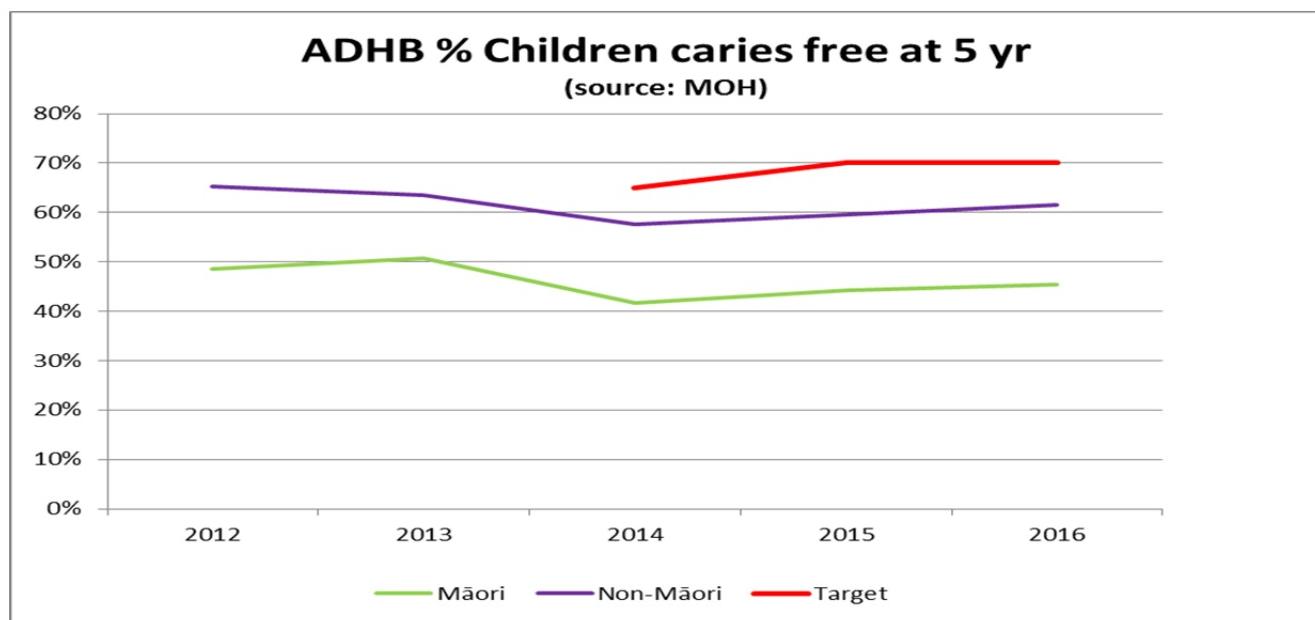
Breast screening



Cervical screening

Primary Options Acute Care (POAC)**ADHB POAC Referrals YTD 2015/16****WDHB POAC Referrals YTD 2015/16**

Children caries free



Question 145 – Appendix 2



Memorandum of Understanding

Between

Te Runanga o Ngati Whatua

and

Waitemata District Health Board

9th May 2001

PROFILE

- **Waitemata District Health Board**

Waitemata DHB is a District Health Board providing hospital, community and home-based services principally to the people of North Shore City, Waitakere City, Rodney and South Kaipara Districts. In addition, Waitemata DHB has a funder role of health services for the district.

Extensive medical, surgical, maternity, mental health and community health services are provided through North Shore Hospital and Waitakere Hospital and a number of sites in the community. These include alcohol and drug services and the school dental services to the Auckland region and forensic psychiatry services at the Mason Clinic and child disability services at the Wilson Home to the Auckland and Northland regions.

Waitemata DHB serves a rapidly increasing population of around 442,000 people and employs approximately 4,000 staff, including full time, part time and casual staff.

- **Te Runanga o Ngati Whatua Trust Profile**

Te Runanga o Ngati Whatua Trust was established on 18 January, 1989 as a Trust Board under the Maori Trust Boards Act 1955. The Runanga is the authorised voice for the Iwi in respect to all issues affecting the whole of the Ngati Whatua rohe.

The Runanga is lead by an 11 member Board of Directors made up of representatives from the 32 marae within the Ngati Whatua rohe. The responsibilities of the Runanga are grouped into five broad functional areas or Responsibility Centres:

- ◆ Rangatiratanga
- ◆ People Development
- ◆ People Caring
- ◆ Economic Development
- ◆ Support Services

Within the five Responsibility Centres, there are ten portfolios which comprise a range of activities closely associated with core responsibility for the Runanga:

RANGATIRATANGA	Rangatiratanga portfolio; Fisheries portfolio
PEOPLE DEVELOPMENT	Education, Employment, Training & Youth portfolio; Cultural & Marae Development portfolio
PEOPLE CARING	Health & Lifestyle portfolio; Environment, Land & Customary Fisheries portfolio
ECONOMIC DEVELOPMENT	Business portfolio; Tourism portfolio
SUPPORT SERVICES	Administration & Finance portfolio

Through the work of its strategic health purchasing and service provision arms, and in accordance with its manaaki tangata obligations the Runanga seeks to achieve demonstrable health gains for all of the 72,255 Maori living within the Ngati Whatua rohe. Te Runanga o Ngati Whatua Trust currently employs approximately 80 staff across its business units.

MEMORANDUM OF UNDERSTANDING dated the 9th day of May 2001

BETWEEN

TE RUNANGA O NGATI WHATUA TRUST a statutory trust board in terms of the Maori Trust Boards Act 1955 (the "Runanga").

AND

WAITEMATA DISTRICT HEALTH BOARD being an organisation established under section 19 of the New Zealand Public Health and Disability Act, 2000 ("WDHB").

1. PREAMBLE

[THE PARTIES] The Runanga and WDHB wish to enter into a partnership for the delivery of health and disability services (health services) in the Rohe o Ngati Whatua.

This memorandum of understanding sets out the basis of the partnership under the headings:

- Background
- Interpretation of Partnership
- Awareness of Relationships and Issues
- Meetings and Procedures
- Information Sharing
- Relationships with Third Parties

2. BACKGROUND

Te Tiriti o Waitangi, (the Treaty of Waitangi) as New Zealand's founding document, establishes the nature of the relationships between Te Tino Rangatiratanga and Kawanatanga. In recognition of s4 New Zealand Public Health and Disability Act 2000 and with a view to achieving the objectives and discharging functions outlined in ss22 & 23 of the legislation the parties now seek to define the nature of those relationships based upon the provisions of the Treaty and the terms of this memorandum. These principles include partnership, manaakitanga, awhinatia, authoritative agency, acknowledgement of obligations, co-operation, goodwill, mutual respect for cultural diversity and equity.

Therefore the Runanga accepts and acknowledges the capacity of WDHB to exercise Article One rights based on Crown agency. In turn, WDHB accepts and acknowledges the capacity of the Runanga to exercise Article Two on behalf of the iwi of Ngati Whatua. Both parties acknowledge that the obligations of the iwi of Ngati Whatua to manaaki all Maori residing within the rohe is implicit in the exercise of te tino rangatiratanga based on the manawhenua status of Ngati Whatua..

Both parties also acknowledge that the principle of partnership implicit in Articles One and Two and as such underpinning the relationship between WDHB and Ngati Whatua is in no way inconsistent with all Maori enjoying the same level of health as non-Maori under Article 3.

Waitemata District Health Board, by statutory and Treaty obligation, intention and explicit expression, is committed to achieving improvements in the general Maori health status within

its defined DHB area.¹ Therefore, the parties now agree to establish relationships, aimed at enabling the achievement of mutually agreed Maori health objectives.

Additionally, the parties further agree, pursuant to the provisions and principles of the Treaty and the principles and terms of this memorandum, to diligently pursue, by all measures that are lawful and in the common good, the ways and means of establishing relationships leading to contracts for health service provision. The provision of these health services shall protect and enhance the particular and general good health status of all iwi Maori, resident within te rohe o Ngati Whatua.

3. INTERPRETATION OF PARTNERSHIP

PARTNERSHIP, within the meaning of this memorandum shall include the acknowledgement and acceptance by both parties;

- a) That each is a bona fide member of a "health partnership", based upon the Treaty. Through this partnership both parties are committed to reducing health disparities and achieving demonstrable health gains through the provision, of effective health services for all Maori resident in te rohe o Ngati Whatua. That both parties acknowledge these to be the partnership's primary purpose.
- b) That the nature of human relationships, essential to the conduct of business between the parties, shall be characterised by equality of status and respect.
- c) That the Runanga shall be consulted early and entitled, under Article Two of the Treaty, to be involved as a Co-Purchaser in all WDHB's planning, purchasing and monitoring decisions impacting upon Maori health, within te rohe o Ngati Whatua.
- d) The WDHB as an agent of the Crown, shall ensure that the working relationships between the parties, encourages equitable opportunities and outcomes.
- e) That contractual relationships between the parties are devised, determined and performed, according to the criterion of "utmost good faith".
- f) That the parties are entitled to practise their respective individual duties, according to the cultural norms of each and that this right shall be subsequently referred to as Nga Kaupapa Tikanga e Rua (two independent cultural forms of conduct).
- g) That the parties, either by explicit agreement or accepted general behaviour, may conduct their dealings with each other in a bi-cultural manner.
- h) That although the parties will always seek to reach mutual agreement this does not in any way imply an obligation on either party to reach such agreement.

¹ see Schedule 1 New Zealand Public Health and Disability Act, 2000.

PROTOCOL 1**AWARENESS OF RELATIONSHIPS AND ISSUES****THE PARTIES**

- a) Shall be represented by personnel who are closely aware -
 - (i) of the need to adopt a more inclusive approach to ensuring appropriate engagement of manawhenua and mataawaka at all levels within the sector.
 - (ii) of the provisions implicit in Te Tiriti o Waitangi, and in particular the range and nature of relationships between Crown and Maori that arise from the various provisions.
 - (iii) of the principles of Te Tiriti o Waitangi and how partnership, participation and protection can be operationalised in the funding environment.
 - (iv) of the provisions and principles of this Memorandum of Understanding and its Protocols.
- b) Shall undertake to respectively increase their awareness of the political, social, economic, religious and historical factors impacting upon the relationships between Maori and the Crown and its agencies.
- c) Shall assist each other to gain greater appreciation of each other's professional and corporate cultural environments, in order to progress the relationship.
- d) Shall provide personnel to attend any jointly organised hui, seminars or mutually beneficial functions, aimed at increasing and improving professional, cultural and social awareness.
- e) Shall give early notice of any anticipated impediments to progress and shall find solutions based upon reasonable compromise.
- f) Shall co-operate in negotiations, whilst keeping as a primary objective and essentiality of Maori involvement in health service provision.
- g) Shall acknowledge and accept, as a "first step" in awareness, that the Maori health status requires urgent and co-operative attention.
- h) Shall acknowledge and accept that the personnel of each party possess particular skills, talents and abilities of mutual benefit to the development of increased and improved awareness between them. Therefore, the parties shall make a commitment to the utilisation of such personnel, in the advancement of their common goals.

PROTOCOL 2 **MEETINGS AND PROCEDURES****THE PARTIES**

- a) Shall meet whenever mutually agreed
- b) All meetings shall be conducted according to the conventional protocols and procedures of the host party.
- c) When or if required, the parties may nominate and engage independent meeting facilitators, selected by mutual agreement.
- d) A written record of the resolutions of meetings shall be kept and when required, circulated as an 'action list' to each party's principal representative.
- e) Subject to the provisions of the Official Information Act 1982, no record of any meeting shall be circulated beyond the representatives of the parties without the prior approval of the respective principal representatives.
- f) The parties shall provide secretarial services for meetings from their own resources as required.
- g) Each party shall be entitled to adjourn meetings by simple verbal notification, for the purposes of holding a "corporate caucus" meeting, but no such adjournment shall exceed one hour.

PROTOCOL 3**INFORMATION SHARING****THE PARTIES**

- a) Shall, in all dealings with each other, acknowledge and accept that all information received or supplied is to serve the "common good" of Maori health needs.
- b) Shall give priority to sharing information that addresses the primary objective of the partnership.
- c) Shall strenuously avoid unjustified notions of "commercial sensitivity" as a means of withholding information.
- d) Shall agree to be bound in all dealings with each other by the various statutes, conventions and lawful practices, prescribing the obligations of secrecy, confidentiality and privacy.
- e) Shall not intentionally withhold relevant information merely because it was unrequested. Proactive volunteering of information shall characterise the co-operative nature of the partnership.

PROTOCOL 4**RELATIONSHIPS WITH THIRD PARTIES****THE PARTIES**

- a) Shall, upon mutual agreement, be free to enter into discussions, negotiations and contracts with third parties where the core business of such third parties is essential or desirable to the objectives of the primary partnership between the Runanga and WDHB.
- b) Shall encourage co-operative and professional relationships between themselves and third party health services providers, where such third party providers –
 - (i) enjoy good service reputations among Maori client groups, and
 - (ii) have been offered explicit human, financial or material resources to the benefit of the objectives of the primary partnership.
- c) Shall retain the primary Te Tiriti o Waitangi relationship of partnership between themselves, when conducting discussions or negotiations with secondary third parties. For the avoidance of doubt, nothing in this clause prevents WDHB from entering into relationships with other Maori.²
- d) Shall diligently pursue the extension of good working relationships with District Health Boards, local General Practitioners and other primary health service providers, operating within the te rohe o Ngati Whatua.
- e) Shall, upon mutual agreement, amend and/or extend the substantive nature of their primary partnership and contractual relationships to include any third party hapu or Iwi or Maori Health organisation (located in and providing services to persons usually resident in the Rohe o Ngati Whatua) which by clear written intention, expresses the desire to join the, "Health Partnership".

² This aligns with Treaty partnership framework as outlined in the Waitemata District Health Board: Establishment Plan 13 October 2000.

The parties having agreed that these Protocols will in future govern their relationship with each, this Memorandum of Understanding is hereof executed:

FOR THE RUNANGA

FOR WAITEMATA DHB

Russell Kemp - Chair



Alison Paterson - Chair



Allan Pivac - CEO

Lynette Gapan
Trustee

Passive
Trustee
L. M. Manley
Director St. Ihi Ora
Mo. Whakapaiher Trustee

D. Rekohere Kemp.
M. Walker

Adam McDowell Jr.

[Signature]

MOU NW - WDHB Final May 2001.doc

Dwayne Crombie - CEO

[Signature]

Donna Johnson
Matai Haere Mai Trustee.

[Signature] Hanauin Trustee

[Signature]
J.R. Woodward.

[Signature]
Jane Edmonds

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**Schedule 1
Other Signatories**

Questions 236, 237, 238 & 243 – Appendix 1

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Information Privacy and Security

Document Type	Policy
Risk level (content)	High
Function	Corporate Administration, Management & Governance
Directorate(s)	Auckland District Health Board Generic
Department(s) affected	All Auckland DHB departments
Applicable for which patients, clients or residents?	N/A
Applicable for which staff members?	All Staff
Key words (not part of title)	
Author – role only	Chief of Intelligence & Informatics
Owner (see ownership structure)	Chief of Intelligence & Informatics
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1. Purpose of policy

The purpose of this policy is to ensure that the appropriate privacy and security measures are in place to protect patient privacy and to safeguard Auckland DHB patient and other personal or business-related information, including appropriate use of Auckland DHB's information systems, networks, equipment and associated infrastructure.

2. Scope

This policy applies to:

- All patient and other personal or business-related information that is collected, created, received, stored, accessed or retained in the course of Auckland DHB business activity, which must be protected according to its level of sensitivity, criticality, or value, regardless of the media on which it is stored or its location.
- All locations from which Auckland DHB information is accessed, including home and offsite/remote use.
- All approved users of Auckland DHB patient and other personal or business-related information including:
 - Auckland DHB Employees (including full time, part time, casual or temporary staff)
 - Agents
 - Contractors
 - Students
 - Visiting health professionals
 - Volunteers

In this policy staff means any of the above, who may collect, create, receive, store, access or utilise Auckland DHB patient and other personal or business-related information, information systems, networks, equipment or associated infrastructure.

3. Responsibilities

Auckland DHB has a responsibility to comply with all legislation, standards, codes and guidelines relevant to the appropriate management of patient and other personal or business-related information.

It is the responsibility of all staff who collect, create, receive, store, access, use, maintain or support patient and other personal or business-related information (systems), regardless of the format of the information, to ensure that information is accurate, stored securely, protected from loss, damage, unauthorised access, alteration or corruption at all times.

All staff are required to:

- Have read, understood and signed the Auckland DHB Staff Agreement – Privacy, Security & Confidentiality of Patients & Other Personal or Business-Related Information, and Appropriate Use of ADHB Systems & Technology – prior to commencing their role.
- Have an appropriate level of understanding of their obligations relating to the use of patient and other personal or business-related information for the area/service in which they work. If in any doubt, they should seek clarification from their Line Manager.
- Undertake appropriate training relevant to their role.
- Adhere to professional standards and legal duty to keep patient and other personal or business-related information safe and secure.
- Familiarise themselves with the contents of this and all associated policies relating to the management of patient and other personal or business-related information.

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4. Definitions

Term	Definition
Business-related information	Any information about ADHB business that does not relate to an identifiable individual or an individual patient (e.g. financial or procurement records).
Corporate record	Any documentation or evidence of activity created by or related to ADHB business, excluding patient information. The term 'corporate record' encompasses personal and other business-related information.
Information	In this policy 'information' refers to patient and other personal or business-related information unless otherwise specified.
Information system	An electronic system used to create, store or provide access to patient and other personal or business-related information.
IT equipment	Hardware (including personal computers and portable devices, such as laptops and cell phones), computer software, printers and facsimile machines.
Malware	A software application that is malicious in nature and intended to compromise information security.
Patient Information	Identifiable information about an individual patient's health or about health services provided to an individual patient, stored within the ADHB clinical record.
Personal information	Any information about an identifiable individual (e.g. personnel/ HR records).
Portable device	An electronic device that is easily physically relocated, such as a laptop or tablet computer.
Removable storage device	An electronic device connected temporarily to a computer to accept or deliver data, such as a USB (Universal Serial Bus) or backup device.

5. Information privacy and security principles

The following principles provide a framework for the management of patient and other personal or business-related information at Auckland DHB.

- Patient and other personal or business-related information will be classified to the appropriate level and in accordance with relevant legislative, regulatory and contractual requirements and Auckland DHB policy.
- All users must handle patient and other personal or business-related information appropriately and in accordance with its classification level.
- Patient and other personal or business-related information should be secure and only available to those with a legitimate need for access.
- Patient and other personal or business-related information will be protected against unauthorised access.

5.1 Privacy of patient information

The Health Information Privacy Code 1994 is a Code of Practice issued by the Privacy Commissioner that gives extra protection to patient information because of its sensitivity.

The 12 rules of the Code substitute for the 12 privacy principles in the Privacy Act 1993.

Auckland DHB has implemented policies, procedures and systems to ensure the privacy of patient information is protected, aligned with the rules in the Code as summarised below:

- Rule 1: Only collect health information if you really need it.

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- Rule 2: Get it straight from the people concerned where possible.
- Rule 3: Tell them what you're going to do with it.
- Rule 4: Be considerate when you're getting it.
- Rule 5: Take care of it once you've got it.
- Rule 6: People can see their health information if they want to.
- Rule 7: They can correct it if it's wrong.
- Rule 8: Make sure health information is correct before you use it.
- Rule 9: Get rid of it when you're done with it.
- Rule 10: Use it for the purpose you got it.
- Rule 11: Only disclose it if you have a good reason.
- Rule 12: Only assign unique identifiers where permitted.

6. Patient privacy - collection, use and display of patient information

- Information for patients about the purposes for which Auckland DHB collects information, and patient rights with respect to their information, will be prominently displayed in patient waiting areas.
- The patient registration process requires all patients to complete a Patient Registration Form (CRO001) which contains a General Privacy Statement, explaining the purpose for the collection of information and the purposes for which patient information may be used.
- By signing the Patient Registration Form patients consent to the collection and use of their information, including sharing of information with other healthcare providers involved in their care.
- Patients may decline permission for use of their information for teaching, presentation or publication. This must be documented in the clinical record and the refusal honoured.
- When collecting information from a patient staff must take all care to ensure that this is done in a location and in a manner that respects the patient's privacy.
- In multi-bed rooms staff should respect patient privacy by obtaining verbal consent for conducting discussions with the patient in the area, and then talking quietly with curtains drawn.
- Staff must check with the patient whether they wish family/whanau to be present for any discussion regarding their care or treatment.
- Wherever possible patients are to be asked on admission to a ward if their name may be displayed on room doors, and above or on beds/cots.
- Patient details that are displayed in public-facing areas (such as room doors, above or on beds/cots) are only to show the patient name, room and the name of the responsible clinician.
- Electronic whiteboards displaying information other than the patient name, room and the name of the responsible clinician must be located and positioned so that they are not public-facing.
- Patients may request that no information be given to persons enquiring; not even that they are in hospital or attending a visit or general information. In response to general enquiries, unless specific consent is given by the patient or their representative, only information about their presence, location and general condition (e.g. satisfactory) may be released.
- Conversations between staff concerning individual patients are to take place in a private location. Conversations must not take place in public lifts, in the cafeteria, on the staff shuttle or using a phone in a public area.

7. Information classification

Staff must be aware of the different categories applied to information in order to ensure information security, privacy and legal compliance.

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7.1 Categories of information

All Auckland DHB information (including information entrusted to Auckland DHB from third parties) falls within one of the following four classifications.

Classification Grade	Classification Description (see notes below)
C1	Unclassified
C2	Internal Use Only/ Commercial : In Confidence
C3	In Confidence
C4	Medical : In Confidence

7.2 C1 (Unclassified)

This is information that may circulate freely in the public domain and, therefore, does not require any special protection. This information might include:

- Published advertising material
- Public statements or announcements
- Published job vacancies

Information marked with this classification must still contain appropriate statements relating to copyright etc.

7.3 C2 (Internal Use Only/ Commercial: In Confidence)

This is information for which unauthorised disclosure, particularly outside the organisation, would be inappropriate and inconvenient. If this information were to be disclosed to a third party, it could provide a commercial advantage. This is routine business information, which the Auckland DHB simply wishes to keep private. This information might include:

- System design information not covered in higher classifications
- Employee contact details
- Organisational charts
- Minutes of department meetings
- Internal Auckland DHB memos or briefings

"C2 Internal Use/ Commercial in Confidence" must be marked or communicated with any material to which it applies.

7.4 C3 (In Confidence)

This is information for which unauthorised disclosure (even within Auckland DHB) could cause significant harm to the interests of the Auckland DHB by virtue of financial loss, loss of profitability or opportunity, embarrassment or loss of reputation. This information might include:

- System information for systems with an Information Classification of C3 or higher
- Patient information
- Negotiating positions
- Personnel information e.g. payroll information, contract information
- IS security testing & review information

"C3 In Confidence" must be marked or communicated with any material to which it applies.

7.5 C4 (Medical: In Confidence)

This is information for which unauthorised disclosure (even within Auckland DHB) could cause serious damage to the interests of the Auckland DHB by virtue of serious financial loss, severe loss of profitability or

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opportunity, grave embarrassment or loss of reputation, and some level of public statement by the MOH. This information might include:

- Patient identifiable data
- Patient Clinical or Medical information

"C4 Medical: In Confidence" must be marked or communicated with any material to which it applies.

(Reference: *healthAlliance Security Functional Standards V6.2, p10-11*)

8. Access controls

8.1 Access to patient information/clinical records

- Staff access to patient information in the clinical record is restricted to only those clinicians involved in the current active care and treatment of the patient, and to other authorised staff whereby access to specific information is required as part of their role.
- Staff as part of their role at Auckland DHB, are likely to have access to electronic systems containing a broad range of patient information. Staff must not misuse their access privileges to access the clinical record or view information about themselves, a family member, friend or any other Auckland DHB patient for which they are not directly involved in providing current active care and treatment.
- Regular audits are conducted to review access by all users of Auckland DHB clinical systems. All potential access breaches (i.e. inappropriate or unauthorised access transactions) are investigated as per the Board Policy - Discipline and Dismissal, and could result in disciplinary action up to and including termination of employment.

Further information regarding access to patient information/clinical records is contained in the Clinical Record Management Policy, including policy statements regarding the following:

- Access for clinical research/clinical trials
- Access for clinical audit
- Access for medical student examinations
- Patient access – release of information

8.2 Access to Information systems containing patient and other personal or business-related information

- Only authorised staff that have a justified and approved business need will be given access to restricted areas containing information systems or stored information.
- Each staff member (if/as appropriate to their role) will be issued with a personal logon for access to the Auckland DHB network and information systems containing patient and other personal or business-related information.
- There is a documented user registration and de-registration procedure for access to the Auckland DHB network and information systems to ensure that access is provided only to current, authorised staff.
- Line Managers must approve user access to the Auckland DHB network and information systems prior to an access request being processed by the IS Service Desk.
- Information system access privileges for all users are based on assigned roles and demonstrated need for access. Access privileges shall be modified or removed as appropriate when a member of staff changes their role or leaves Auckland DHB employment.

8.3 Use of Passwords

- Passwords are the primary security credentials used to identify, authenticate and authorise access to the DHB network and information systems.
- Passwords are automatically classified as C3 - In Confidence and must be protected appropriately.

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- Staff are responsible for keeping all passwords confidential.
 - Passwords must never be disclosed to or shared with another person.
 - Logon/user names and passwords must not be sent by public, external email.
 - Staff must not record their passwords in any way that they could be accessed by another person.
 - Staff must not ask any other staff for their password.
 - Staff must not let anyone observe the entering of a password.
- Each staff member must log on to any information system using their own logon to avoid working under another staff member's logon.
- All staff will be held accountable for all computer/device activity and transactions made using their personal logon, whether or not they are present at the time.
- Staff must select passwords that conforms to the selection criteria below.

8.4 Selection criteria for passwords

- Have a minimum length of 8 characters.
- Have complexity enabled consisting of at least three of the four following character sets:
 - lowercase characters (a-z)
 - uppercase characters (A-Z)
 - digits (0-9)
 - special characters such as !@#\$%^&*
- Do not base passwords on any of the following details:
 - family names
 - initials
 - car registration numbers
 - user name
 - more than two consecutive identical characters
 - obvious phrases or sequences such as '12345678'

The best type of password is one that is made up from a 'Passphrase' such as "WeLikeApples10!".

8.5 Suspected disclosure of password

If you suspect your password has become compromised you must change it immediately and report an incident, as noted in Section 11 of this Policy.

9. Information privacy and security

Staff must ensure that patient and other personal or business-related information, regardless of the format in which it is created, used or stored, is accurate, stored securely, protected from loss, damage, unauthorised access, alteration or corruption, and that confidential information is protected at all times. The safeguards outlined in this and associated policies are in place to ensure the security and privacy of patient and other personal or business-related information.

9.1 Storage and transport of clinical records

- Clinical record storage methods should ensure that access is restricted to authorised persons only at all times.
- Clinical records shall be stored in such a way so as to protect them from physical damage and/or electronic corruption.
- Clinical records must never be removed from Auckland DHB, e.g. to private rooms, the staff member's home, or other institutions.
- When transferring paper-based clinical records from one location to another, patient privacy must be maintained by ensuring that no patient identification details are visible during transfer.

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- When transferring paper-based records between Auckland DHB campuses (e.g. from Auckland City Hospital to Rehab+) clinical records are to be transported in a secure file or locked case.
- Under no circumstance should clinical records be left in an unattended vehicle or in any unsecure location.
- Patient information from, or for, a clinical record must never be permanently stored:
 - on Auckland DHB owned or personal cell phones, computers, portable devices or removable storage media including, but not limited to, smart phones, laptop computers, tablets, personal digital assistants (PDAs), USB/flash drives and memory cards
 - in a personal or shared drive on the Network
 - in an unprotected location.

9.2 Use of cloud storage for patient and other personal or business-related information

In accordance with advice issued by the National Health IT Board (NHITB), no patient information is to be stored in a cloud that is based off-shore. The NHITB states that:

"Unless exemption is granted by the National Health IT Board, all personally identifiable health information and core operational data must be fully domiciled in New Zealand."

The NHITB recognises that off-shore and/or cloud technology may offer a low-cost option for storing information but says this has to be considered alongside the requirements health and disability support service providers have under the Privacy Act 1993, Health Information Security Framework (HISF) and Health Information Privacy Code 1994 (the Code) to protect information they hold from loss, misuse and/or unauthorised access, use, disclosure or modification. Sending or storing health information overseas means that it would be controlled or accessed outside New Zealand's jurisdiction. Under the Code, a service provider is responsible for information they have in a cloud." (Disability Support Services e-newsletter, February 2013, p. 4.).

Auckland DHB prohibits the use of cloud storage to store or transmit any ADHB C2, C3 or C4 classified information unless prior exemption from the NHITB has been granted.

9.3 Privacy and security controls – information systems and electronic devices

- Monitors, keyboards and workstations must be positioned in such a way that restricts access to or viewing of patient and other personal or business-related information to authorised staff only.
- Cell phones, portable devices and removable storage media that may contain patient and other personal or business-related information must be appropriately secured (i.e. locked away in filing cabinets or offices) when not in use, and should not be left unattended in meeting rooms or unlocked offices.
- All removable data storage devices must be encrypted and password protected.
- When a computer/device is switched on, it is essential that staff log out or 'lock' the screen before they leave the computer/device unattended.
- At the end of a session/shift, or when leaving Auckland DHB controlled premises staff must do a full shut down of the computer/device to ensure it is secured.

9.4 Privacy and security controls – sending patient and other personal or business-related information classified as C2, C3 or C4 via facsimile

- When sending patient and other personal or business-related information classified as C2, C3 or C4 to any recipient via facsimile (fax), a fax header sheet must be attached. The header sheet must state who the information is intended for and must also include the following standard, approved Confidentiality Statement and Disclaimer:

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"Information contained in this message includes confidential patient or other personal or business-related information. If you are the intended recipient you are required to keep this information private. If you are not the intended recipient your use or retention of this information will breach the Privacy Act. If you have received this message in error please destroy it and notify the sender by telephone immediately."

- Saved speed-dial numbers should be used for common fax recipients to prevent numbers being misdialed. These numbers should be tested periodically.
- When sending a fax to a new recipient, where practicable staff should verify the fax number before sending patient and other personal or business-related information classified as C2, C3 or C4.
- Fax machines should be located in a secured area where only staff who are authorised to use the machine to send and/or receive faxes can access it.

9.5 Privacy and security controls – sending patient and other personal or business-related information classified as C2, C3 or C4 via email

Use of email for sending patient and other personal or business-related information classified as C2, C3 or C4 to recipients outside the Northern Region DHB secure Network is not encouraged, as this is a non-secure means of transmission of information. However, it is recognised that from time to time it may be necessary to support timely exchange of information with recipients outside the Northern Region DHB secure Network (including patients) via the use of email. This communication mechanism may therefore be used by exception, and should not be adopted as standard practice.

Recipients outside the Northern Region DHB secure Network are identified via a pop up message that appears when the recipient's email address is entered into the 'To' field in the email system.

The following safeguards must be adhered to when transmitting patient and other personal or business-related information classified as C2, C3 or C4 in or attached to an email to recipients outside the Northern Region DHB secure Network.

- Ensure you have the correct email address for the intended recipient. Where practicable, verify the email address by sending an email first to confirm with the intended recipient that it is appropriate to use that email address.
- No patient or other personal or confidential business-related information (including information that identifies an individual patient) must be displayed in the subject line of an email.
- Send patient and other personal or business-related information classified as C2, C3 or C4 in an attachment (Word, Excel etc.) with encrypted password protection. The password should be sent to the intended recipient, preferably by phone or other non-email communication.
- Wherever possible, patient names should be excluded from email messages. Patients should be referred to by their NHI number only.
- Limit email content to the minimum amount of information necessary to meet the intended purpose.
- If communicating with a patient via email, ensure you have the patient's consent to do so and record this in the patient's clinical record. Consider whether a copy of the email communication should be sent to the Clinical Records Department for scanning into the 3M ChartView clinical record. This is a requirement if the email pertains to the care or treatment provided to the patient.

9.6 Privacy and security controls - use of answering machines/voicemail

- Avoid leaving messages about or for a patient on an answering machine/ voicemail unless you have specific consent to do so.
- When urgent contact is to be made the only information that is acceptable to leave is a telephone number and the name of the person to phone back.
- Auckland DHB voicemail must always be password protected so it can only be accessed by authorised staff.

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- The password for voicemail should not be the same as the owner's telephone extension number.

10. Security of IT equipment

In order to minimise loss or damage and to avoid interruption to Auckland DHB business activity, all IT equipment, including hardware (personal computers and portable devices, such as laptops and cell phones), computer software, printers and facsimile machines and information storage areas must be physically protected from security threats and unauthorised access.

- Where possible IT equipment should be positioned away from public accessible areas, preferably in secure locations.
- At the end of each day/work shift, all portable devices and confidential hard copy information must be appropriately secured (i.e. locked away in filing cabinets, offices etc. as appropriate).
- All printers and fax machines should be cleared of papers as soon as they are printed.
- Information held electronically must be stored in the appropriate drive on the Auckland DHB network. Information should not be saved to the Desktop, C Drive or 'My Documents'.

10.1 Disposal of IT equipment and personal or other business-related information

- The IS Service Desk must be informed of any IT equipment that needs to be disposed of. Under no circumstances must staff pass on or dispose of IT equipment themselves.
- Staff should refer to the Corporate Information Management Policy and DHB General Disposal Authority for guidance on the retention periods that apply to personal or other business-related information.
- On a day-to-day basis confidential waste (i.e. information classified as C2, C3 or C4) must either be shredded or disposed of in the designated confidential waste bins.
- The secure disposal of information classified as C2, C3 or C4 that has reached the end of the required retention period as per the DHB General Disposal Authority must be managed via secure destruction.

10.2 Return of equipment and removal of access rights

- All IT equipment, including hardware (personal computers and portable devices, such as laptops and cell phones), computer software, working materials, confidential information, and other property issued to staff must be returned upon termination of their employment contract.
- It is the responsibility of the Line Manager to inform the IS Service Desk when a staff member has left Auckland DHB so that network and information system access rights can be removed.

10.3 Remote access

All computers which have remote connections with the Auckland DHB network and information systems must have virus-scanning software installed with the latest security patches and updates applied.

10.4 Electronic Mail and Internet Use

Please refer to the Electronic Mail and Internet Usage Policies.

11. Privacy and security incident management and response

Privacy and security incident management procedures are in place to ensure a quick, effective, and orderly response when privacy and security incidents occur, to enable monitoring and learning from such incidents, to mitigate the risk of and avoid recurrence.

Privacy and security incidents include but are not limited to:

- Loss or theft of hard copy patient and other personal or business-related information or equipment such as laptops or USB/flash drives on which information is stored.
- Malicious software or virus attack on the network, IT equipment or information systems.

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- Inappropriate access controls allowing unauthorised use of patient and other personal or business-related information.
- Attempts to gain unauthorised access to the network, IT equipment or information systems.
- Denial of service - an attack that prevents or impairs the authorised use of the network, IT equipment or information systems.

Staff are required to report any observed or suspected incidents to their Line Manager.

All incidents must be reported by the Line Manager to the IS Service Desk and logged via Risk Monitor Pro, including:

- Full contact details of the user (name, contact number and email address)
- IT equipment type, model and serial number
- A short summary of the incident.

12. Software installation

To comply with the law on the use of licensed products and minimise the risk of computer viruses, ADHB only permits the installation of approved software on Auckland DHB owned or managed devices. Software which does not have a legitimate licence for its use, or may be used for malicious purposes (i.e. hacking tools, etc.) must never /be installed or used on an Auckland DHB owned or managed device.

12.1 Installing software

- If a user requires access to new software they must submit a request to the IS Service Desk.
- Software must not be downloaded and installed by users.
- If the requested software is not in the approved software catalogue the IS Service Desk will acquire the software.
- The IS Service Desk will arrange for new software to be installed on specified device/s so that care can be taken to mitigate the risk of viruses.

12.2 Antivirus software

All devices (desktop, laptops etc.), whether connected to the network or stand-alone, must have the healthAlliance approved antivirus and malware scanning /detection software installed and active at all times.

13. Modems or network devices on workstations connected to internal networks

Computer users are prohibited from connecting modems or any network device to workstations which are simultaneously connected to a local area network (LAN) or another internal communication network unless approval has been obtained from healthAlliance.

14. Personal use

IT equipment and information systems are provided for the conduct of official Auckland DHB business. Limited personal use may be permitted at the discretion of the Line Manager, provided such use is not excessive or inappropriate and does not result in expense or risk to ADHB or otherwise violate this policy.

15. Prohibited use

- Using or attempting to use another individual's user name or password.
- Engaging in any activity that might be harmful to IT equipment or information systems, or to any information stored thereon, such as creating or propagating viruses, disrupting services, damaging files, or making unauthorised modifications to or sharing of Auckland DHB information.

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- Using Auckland DHB information systems for commercial purposes or personal gain.
- Attempting to gain access to Auckland DHB information systems or patient and other personal or business-related information to which the staff member has no legitimate access rights.
- Engaging in any other activity that does not comply with this or related policies, or applicable legislation.

16. Legislation

- Copyright Act 1994
- DHB General Disposal Authority (DA262)
- Health Information Privacy Code 1994
- Official Information Act 1982
- Privacy Act 1993
- Public Records Act 2005

17. Associated Auckland DHB documents

- [Cellphones](#)
- [Clinical Record Management](#)
- [Corporate Information Management](#)
- [Electronic Mail](#)
- [Internet Usage](#)
- [Patient Registration](#)

Clinical Forms

- [Patient Registration Form \(CR0001\)](#)

18. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed *before* the scheduled date, they should contact the owner or the [Document Controller](#) without delay.

Question 241 – Appendix 1

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Mobile Device

Document Type	Policy
Risk level (content)	High
Function	Corporate Administration, Management and Governance
Directorate(s)	Organisation Wide
Department(s) affected	All departments, services and units
Applicable for which patients, clients or residents?	n/a
Applicable for which staff members?	All staff members who use a mobile phone for Auckland DHB related business
Key words (not part of title)	Acceptable, USB, device, email, images, messages, photography, prohibited, text, use
Author – role only	Chief of Informatics
Owner (see ownership structure)	Chief of Informatics
Edited by	Document Controller
Date first published	June 1998
Date this version published	28 July 2017 - updated
Review frequency	3 yearly
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1. Purpose of policy

This policy is to provide governance, relating to the allocation and use of mobile devices within the Auckland District Health Board (Auckland DHB). The Mobile Device policy has been developed to define a standardised process for the management and use of mobile devices.

2. Scope

The Mobile Device Policy applies to:

- ALL Employees, full, part time or casual, consultants, contractors, volunteers and other agents working for or on behalf of Auckland DHB (collectively referred to as "staff") who use a mobile device in the course of their work; AND
- ALL mobile devices that are used to gain access to corporate information, networks and systems, whether provided by Auckland DHB, personally owned (under the BYOD programme) or provided by other parties.

3. Definitions

Term	Definition
BYOD	Bring your own device
BYOD Programme	Programme allowing eligible staff to use personally owned mobile devices within Auckland DHB to connect to and use appropriate corporate information, networks and systems.
Mobile Devices	Defined in this policy as phones, tablets and other smart devices, running a Mobile Operating System that can be secured and managed by the Mobile Device Management system.
Mobile Plan	Mobile SIM card and associated plans from a telecommunications provider.
Mobile Operating System	Mobile Operating systems are the software such as iOS, Android and Windows Phone that operates mobile devices such as smartphones or tablets. These devices are not typically domain joined and are managed outside of the organisations network using mobile specific tools.
Mobile Service	Mobile Device and mobile plan and any other related services.
Corporate Wipe	Deletion of all Auckland DHB provided data, access and applications will be completed immediately
Full Device Wipe	The deletion of all apps and information, effectively performing a device reset.
Auckland DHB connection	A mobile phone connection with the current Auckland DHB preferred mobile phone supplier. Such a connection is deemed necessary for employment and is paid for by Auckland DHB
Private Connection	A mobile phone connection in the name of the staff member for personal use and not deemed necessary for employment

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4. Responsibility

Role	Responsibility
Regional Mobility Steering Committee	Ownership of the Regional Mobile Policy and responsible for governance and change management.
CIO	Ownership of Mobility Strategy and ensuring it is fit for purpose.
healthAlliance	Responsible for BAU management, service levels and support of mobile assets & services. Define, procure and manage the services, infrastructure, hardware and applications to cater for telecommunications needs and provide secure access to corporate information, networks and systems at its sole discretion.
Managers	Ensure mobility needs of staff are met and manage process and costs as directed by the Auckland DHB Mobile policy and guidelines.
Staff	Abide by Auckland DHB policy, and procedures. Ensure corporate information, networks and systems used on mobile devices are kept secure.

5. Eligibility for Auckland DHB Connection

Auckland DHB will pay for the cost of business related mobile device operation when a mobile device is deemed necessary for employment. This is known as an Auckland DHB Connection.

An Auckland DHB mobile phone connection will be allocated on the following basis:

- Allocation guidelines:
 - The role requires the person to be contactable during work hours and / or contactable out of work hours
 - The role requires the person to be mobile and work across locations and sites
 - An existing connection cannot be re-allocated to the requestor
 - A pool mobile device cannot be shared with the requestor
 - Budget exists for connection, payment of device, maintenance / upgrade and ongoing operational costs of its use
 - The request has the approval of the relevant Line Manager
- Approval for new mobile device connection:
 - Line Manager justification and approval is logged via the IS Service Desk Portal for verification to allocation guidelines

6. BYOD (Bring Your Own Device) Programme

Auckland DHB offers an optional programme, whereby eligible staff may use an approved personally owned mobile device enrolled, secured and managed by Auckland DHB, to securely access corporate information, networks and systems.

The purpose of the BYOD programme is:

- To provide flexibility for staff who are eligible for a standard Auckland DHB provided mobile device but choose to use or upgrade to a different device of their choice;

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- To allow staff who are not eligible for an Auckland DHB provided mobile service to securely and appropriately access certain Auckland DHB corporate resources they may require, on their personally owned mobile device and plan;

The following conditions are mandatory for entry into and ongoing use within the BYOD programme:

- Any personal device opted into the programme is subject to all provisions in the Mobile Device Policy, including the appropriate security and management by Auckland DHB.
- Staff who are eligible for a Auckland DHB provided mobile service must use an Auckland DHB corporate SIM card and plan with a personally owned device. Staff who choose to use a personal mobile plan and SIM card will be responsible for all costs incurred.
- Staff are responsible for ALL initial and ongoing costs, insurance, support, repairs or replacement associated with the use of their personally owned mobile device (including any use of a personal plan if not using a Auckland DHB provided mobile service).

7. Asset Management

Mobile phones and accessories supplied by Auckland DHB remain the property of Auckland DHB.

As part of the exit process or when requested at any time, Auckland DHB mobile devices must be returned to the IS Service Desk with all accessories provided.

Auckland DHB will take no responsibility for any personal data residing on the device when it is returned.

Lost or stolen Auckland DHB mobile devices must be reported immediately to the IS Service Desk and Line Manager.

Any loss of or damage to an Auckland DHB mobile phone is the responsibility of the user. Their Line Manager will be required to pay for either the repair or replacement of an equivalent new mobile phone from the appropriate RC.

Line Managers are responsible for monitoring the overall cost of every mobile device used by members of their team. Audits must be conducted on mobile device usage to ensure compliance with acceptable use.

8. Mobile Device Enrolment

Mobile devices will be registered in a Mobile Device Management (MDM) tool. This tool will enforce certain policy settings.

Enrolment involves installing an MDM client app from the device's app store, and configuring the app to link to the management tool.

Enrolment will register the device and the user of the device. Applications and custom configuration settings can then be pushed to the device.

Uninstalling the MDM client app will deregister the device from the management tool and will render the corporate apps inoperable.

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8.1 Overview Enrolment Process

- The MDM app will be installed on the device
- The app will be configured to point to the hA MDM platform
- Applications can be automatically pushed, or user pulled, from the hA App Store available within the MDM container
- Installing the MDM app on the device and connecting to the hA MDM platform completes the enrolment process, and means the device is now registered on the MDM and can be managed.

9. Acceptable use

The Auckland DHB staff member to whom a mobile device is allocated has the responsibility for ensuring that the mobile device is used in a responsible manner for business purposes.

While Auckland DHB accepts the use of corporate mobile device plans for reasonable personal use, staff are expected to observe common sense at all times and will be held accountable for any non-standard, excessive or negligent usage or charges. Excessive use is defined as usage that is outside reasonable expectations and that may exceed the plan allowance or prevent the staff member from doing their job.

Auckland DHB reserves the right to have the staff member reimburse expenses not associated with appropriate business use.

Where a mobile device is capable of email and / or internet access, all use of these facilities on the mobile phone is governed by the terms of the relevant Auckland DHB Policies, such as the Email and Internet Usage Policy.

All information, including emails, text messages and call information, stored in or sent via an Auckland DHB mobile device is the property of the Auckland DHB and subject to the requirements of the Privacy Act 1993, Health Information Privacy Code 1994 and the Public Record Act 2005. Auckland DHB reserves the right to review this information at all times.

10. Prohibited use

This list of prohibited activities is not exhaustive, but attempts to provide a guideline for activities which fall into the category of unacceptable use of any mobile device used for business purposes:

- Use, storage or distribution of sensitive information (such as corporate, medical or private information) outside of Auckland DHB sanctioned access or applications
- Consumption, storage or distribution of material that may be deemed offensive, pornographic, racist or sexist
- Making calls to 0900 numbers or other services not related to Auckland DHB business requirements
- Use, storage or distribution of copyright content or software
- Using the mobile device of another staff member for any purpose without their permission
- Using the mobile device for conference calls when a landline connection is available. Staff should consider the cost of using a mobile phone for these types of calls.

Misuse of a mobile device may be regarded as a disciplinary matter and dealt with as per the Discipline and Dismissal Policy.

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11. Appropriate use of clinical images / photography

Clinical images / photography captured on a mobile device form part of the patient record and are subject to the same confidentiality and privacy principles as any other element of the record. Staff must comply with the requirements of the Informed Consent Policy.

All mobile device users must ensure that the privacy of all visitors, patients and staff are respected. This means that taking images / photography of individuals (including those appearing in the background) for clinical purposes must only be done with the specific consent of the individuals or the consent of the carers of the individuals unless otherwise permitted under legislation.

Recorded images / photography of a patient in the course of their treatment must be documented in the patient's record, including the details of the consent provided by the patient or their representative.

The images / photography may not be used, stored or shared for any purpose other than for which consent was given, or disclosure is allowed under the Health Information Privacy Code.

All images / photography must be identified by patient NHI, surname, date of birth and the date of capture.

See instructions on how to email images / photography to the patient record:
<http://adhb.intranet/HIMS/ChartView/QC%20Emailing%203MChartView.pdf>

Once an image / photography has been incorporated into the patient's clinical record it must be deleted from the mobile phone immediately.

12. Appropriate use of text messaging

Whilst there may be benefits to both patients and Auckland DHB from the use of text messaging, this is not a secure method of communication.

Staff must always ensure that the patient is aware of the risks associated with communicating in this way and that this has been agreed and documented as part of the patient record.

Text messaging should not be used in an emergency, and mobile device users should be careful about using this method of communication when information provided by the patient indicates a face-to-face intervention or clinical assessment is needed.

Any information relevant to the patient's ongoing care must be captured in the patient record.

13. Usage Overseas

The use of any mobile device overseas is expensive. If roaming services are required for business purposes, prior approval is required from the CFO. Unintended roaming use is not an excuse and staff will be held accountable for any unapproved or excessive roaming charges.

14. Usage whilst driving

It is illegal to drive whilst using a hand held mobile device in New Zealand as well as many other countries around the world. Staff are advised that they are personally accountable for any such offences, regardless of the circumstances.

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Auckland DHB's position is that no employee, is to use ANY handheld mobile device whilst driving. Auckland DHB accepts no responsibility for any incident, violation and / or legal action arising from illegal use of ANY device whilst driving.

15. Security of mobile devices & content

Staff issued with an Auckland DHB owned mobile device must take all reasonable precautions to prevent theft, damage, misuse or unauthorised use. To protect the security and confidentiality of business related information, Auckland DHB owned mobile devices must not be left unattended in unsecured locations at any time, including in the office, private premises or in vehicles.

Only approved mobile devices will be provided access to corporate information, networks and systems.

A security and management tool will be used as part of Auckland DHB's security environment to manage mobile access to corporate information, networks and systems for ANY device used for business.

It is mandatory that ANY device used for business be secured and managed by Auckland DHB. Access to corporate services will only be provided to devices that are secured and managed.

A passcode is mandatory on any mobile device that is used for business purposes. Staff must never disclose a password or pin at any time to anyone nor store their password in an unsafe location.

A Voicemail PIN should be set up by every user.

Staff must not allow other people (staff, family members or friends) to use their Auckland DHB mobile device.

It is the personal responsibility of staff to regularly backup any personal information, media, applications or settings.

Encryption of device backups is mandatory for ANY device used for business purposes and will be enforced by Auckland DHB.

Auckland DHB will not be held accountable for the loss of any personal content for any reason. This applies to devices owned by Auckland DHB and devices owned by staff.

16. Security of information, networks and systems

Access to corporate information, networks and systems on mobile devices is allocated at Auckland DHB's sole discretion. Auckland DHB reserves the right to restrict, prevent or remove this access at any time.

Confidential, sensitive or private information MUST NOT be stored or used on any device unless using Auckland DHB approved and provided access and applications.

Staff understand and accept that Auckland DHB has the right to perform a Corporate Wipe from any mobile device at any time.

Any attempt to contravene or bypass security requirements on any mobile device used for business purposes is regarded as a security breach and a breach of conduct, and may in appropriate cases be regarded as serious misconduct and dealt with in accordance with the Discipline and Dismissal policy.

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17. Lost, Stolen or Breached Devices

Due to the risk of a security breach, staff are expected to inform the Service Desk immediately if a device is lost stolen or breached in any way.

The following process will be followed:

- The device will first be locked to prevent access;
- If possible it will be geo-located;
- A Corporate Wipe will be employed (removing all corporate information and access);
- The mobile plan will be blocked and the device blacklisted (where applicable);
- If the device is stolen, you are expected to file a police report within 24 hours;

Where a managed device (Auckland DHB owned or BYOD) is not located within 24 hours of when the device was lost, the employee will be notified that a Full Device Wipe will be commissioned. This will help protect any corporate information as well as any personal data still on the device.

18. Software and Applications

Auckland DHB reserves the right to have visibility of all applications (however specifically NOT the content) installed on any mobile device used for business purposes.

Auckland DHB will provide and remove any software or applications (and related licensing) required for business purposes at its discretion.

- Staff are responsible for purchasing and paying for any other mobile device applications or content that they may choose to use.
- Auckland DHB may maintain a list of "Blacklisted" Applications that are prohibited on any mobile device used for business purposes.

19. Legal and Privacy

Any device used for business purposes, may be requested in the event of a legal discovery process. If a mobile device contains information relevant to legal proceedings, a legal representative of Auckland DHB may request the device.

Auckland DHB will maintain its responsibility to respect and protect privacy at all times.

With respect to the above, staff understand and accept:

- Auckland DHB ensures that any mobile security initiative will not be used to access or store personal content (such as SMS, Personal Email, Photos)
- Geo-location may be used to track corporate devices in the event that they are lost or stolen or for other business specific purposes. Staff will be advised in advance of and in accordance with any policy or legislation.
- At any time Auckland DHB may need to inspect any mobile device used for business purposes for the purpose of security compliance.

20. Private connection

Auckland DHB will reimburse the cost of mobile phone operation if individual calls are made on behalf of Auckland DHB on a staff member's private connection.

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20.1 Lodgment of claim

Calls of this nature may be claimed in the same way as any personal work related expense claim as per the Auckland DHB Policy on Personal Work Related Expenses, by attaching a copy of the invoice to the expense claim and highlighting the call details).

20.2 Management approval

When using a private mobile device for Auckland DHB purposes the staff member where practical, should obtain prior approval from their Line Manager, particularly if this will be a standing arrangement.

20.3 Mobile device usage audits

Line Managers are responsible for monitoring the overall cost of every mobile device used by members of their team. Audits must be conducted on mobile device usage to ensure compliance with acceptable use.

20.4 Considerations

Key issues to consider when evaluating the appropriateness of charging the cost of a call to Auckland DHB are:

- Is the call business or personal?
- Could the call be made using a cheaper option such as a landline connection?
- Is the length / frequency of calls excessive when compared to those of other staff and generally accepted practices?
- Would public disclosure of the calls being reimbursed by Auckland DHB cause embarrassment to the organisation and / or the staff member?

21. Legislation

- Health Information Privacy Code 1994
- Land Transport (Road User) Amendment Rule 2009
- Privacy Act 1993
- Public Records Act 2005

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22. Associated Auckland DHB documents

- [Cellphone Risk & Other Communication Devices](#)
- [Clinical Record Management](#)
- [Electronic Mail](#)
- [Expenses - Personal Work Related](#)
- [Informed Consent](#)
- [Internet Usage](#)
- [Motor Vehicles - Board](#)

23. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed before the scheduled date, they should contact the owner or the [Document Controller](#) without delay.

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Question 246 – Appendix 1

	Supporting Service								
Key Application	Clinical & Specialty Services	Clinical Support Services	Enterprise Resource Planning Services	General Management	Operational / Administrative Support Services	Patient Support Services	People & Corporate Support	Technology Services	
3M ChartLinc - ADHB								X	
3M ChartQ - ADHB	X	X	X		X	X		X	
3M ChartRelease - ADHB	X	X	X		X	X		X	
3M ChartScan - ADHB	X	X	X		X	X		X	
3M ChartScript - ADHB	X	X	X		X	X		X	
3M ChartView - ADHB	X	X	X		X	X		X	
3M Codefinder - Regional					X				
3M eSignature - ADHB					X				
Actor - ADHB			X						
Business Objects - ADHB	X		X	X	X	X	X	X	
CIS - ADHB	X								
Clindocs - ADHB	X								
Clinical Referral Portal - Regional	X	X							
CMS A+ - ADHB	X	X	X		X	X	X	X	

CMS A+ - Training - ADHB	X	X	X		X	X	X	X
CMS Admin Tools - ADHB	X	X	X		X	X	X	X
CMS Bed Management - ADHB	X	X	X		X	X	X	X
CMS Booking System - ADHB	X	X	X		X	X	X	X
CMS Booking System Admin - ADHB	X	X	X		X	X	X	X
CMS CHIPS - ADHB	X	X	X		X	X		X
CMS CMCS - ADHB	X	X	X		X	X	X	X
CMS Context - ADHB	X	X	X		X	X	X	X
CMS CRTS Configuration - ADHB	X	X	X		X	X	X	X
CMS CRTS3 - ADHB	X	X	X		X	X	X	X
CMS CRTS3 Backup System - ADHB					X			
CMS Data Viewer - ADHB	X	X	X		X	X	X	X
CMS Delphic Maintenance Tool - ADHB	X	X	X		X	X	X	X
CMS Enquiries - ADHB	X	X	X		X	X	X	X
CMS Maintenance Tool - ADHB	X	X	X		X	X	X	X

CMS non-specified - ADHB	X	X	X		X	X	X	X
CMS View - ADHB	X	X	X		X	X	X	X
Colposcopy - ADHB	X							
Concerto - ADHB	X	X	X		X	X		X
Decryptic - ADHB,NDHB	X	X	X		X	X		
Delphic AP - ADHB,NDHB	X	X	X		X	X		
Delphic Explorer	X	X	X		X	X		
Delphic Fax Module - ADHB,NDHB	X	X	X		X	X		
Delphic Haematology - ADHB	X	X	X		X	X		
Delphic Latte - ADHB, NDHB	X							
Delphic LIS - ADHB,NDHB	X	X	X		X	X		
Delphic Microbiology - ADHB,NDHB	X	X	X		X	X		
Delphic On The Web (DotW) - ADHB, NDHB	X	X	X		X	X		
Delphic Pate - ADHB	X	X	X		X	X		
Delphic Reg - ADHB,NDHB	X	X	X		X	X		
Delphic Sendaway - ADHB,NDHB	X	X	X		X	X		

Dr.Completion - ADHB	X	X			X	X		
Eclair - Regional	X	X			X	X		X
Eclair Radiology Orders Entry System (ROERS) - ADHB	X	X			X	X		X
Eclair ROERS - ADHB	X	X			X	X		X
Eclair Web Service - Regional	X	X			X	X		X
ePharmacy - ADHB, NDHB		X						
ePrescribing Medchart - ADHB		X				X		
eReferrals - Regional	X				X	X		
HCC Community and Sexual Health - ADHB	X				X	X		
HCC Mental Health - Regional	X				X			
Healthware - ADHB	X				X			
Healthware proxy listener/server - ADHB	X				X			
iBleep - ADHB	X				X			
IMPAX - Regional	X	X		X	X			
IMPAX ADHB (Service Tools) - ADHB	X	X			X	X		
IMPAX Interface Server - ADHB	X	X			X	X		

IMPAX Picture Archiving and Communications System-ADHB - ADHB	X	X			X	X		
IMPAX Xero - Regional	X	X			X	X		
iPM (PIMS) Theatre Module - ADHB	X				X			
iPM (PIMS) Theatre Module Training - ADHB	X				X			
Kiosk - ADHB	X	X	X	X	X	X	X	X
Leader - ADHB			X					
Milestone Camera - ADHB			X					
MOH Reporter - ADHB	X	X	X		X	X	X	X
NBRS Reporter - ADHB	X	X	X		X	X	X	X
Neonatal - ADHB	X		X		X			X
NHI SSR gateway - ADHB	X	X			X	X		
NHI vt220 gateway - ADHB	X				X			
NNPAC Reporter - ADHB	X	X	X		X	X	X	X
Patch Definition - ADHB	X	X	X		X	X	X	X
Pathways Healthcare					X			

Scheduling - ADHB								
Pathways Healthcare Scheduling Gateway - ADHB					X			
Patient Facing Dashboard - ADHB	X	X	X		X	X	X	X
Patient WCF Service - ADHB	X	X			X	X		
Patient.Net - ADHB	X	X			X	X		
Pims Web - ADHB	X	X	X		X	X		
Pre Allocated Labels - ADHB	X	X	X		X	X	X	X
PRIMHED Reporting - ADHB	X				X			X
Radiology Information System - Regional	X	X			X	X		
Radiology Information System (RIS) QDoc Module - ADHB	X	X			X	X		
Radiology Information System Interface - ADHB	X	X			X	X		
Regional Patient Web Service - Regional	X	X			X	X		
RIS HL7 Interfaces - ADHB	X	X			X	X		

Risk Monitor Pro - ADHB	X	X	X	X	X	X	X	X
Safer Sleep - ADHB,WDHB	X	X						
Soprano Medical Documents - ADHB	X	X			X	X		X
Soprano Medical Templates - ADHB	X	X			X	X		X
Toniq - ADHB		X						
User Notifications - ADHB	X	X	X		X	X	X	X
Visit View - Regional	X	X			X	X		
Visit.Net - ADHB	X	X			X	X		
Winscribe - Regional	X				X	X		
Workforce Central - ADHB,WDHB	X	X	X	X	X	X	X	X

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Question 285 – Appendix 1

Name of Project	Total Project Budget	Costs to 30 June 18	Start Date	Completion Date
ADHB Managed Projects				
CMS Enhancement Analysis	120,000	119,990	Jul-14	Nov-17
Genetics Clinical Database	157,909	154,347	Jun-13	Feb-18
ACC Elective Surgery Database	160,050	141,176	Jun-17	Dec-18
Mental Health Data Mart	165,000	116,550	Mar-18	Jun-19
Patient Email & Mobile No Vali	181,004	243,441	Aug-17	Feb-19
ePA Implementation Marion & Ra	184,409	129,134	Dec-16	May-18
National Patient Flow Phase 3	195,000	138,575	May-16	May-18
HCC Concerto Integration	210,800	146,048	Oct-17	Mar-19
ADHB Leader Upgrade	255,852	40,600	Dec-16	Dec-19
IS Stabilisation Phase 2	280,000	92,731	May-18	Feb-19
MPS Platforms	294,000	238,529	Jun-17	Jun-19
MFM View Point Upgrade	315,933	33,126	Nov-17	May-19
MUSE Replacement	329,301	58,179	Aug-17	May-19
Need to Approval System	343,800	9,200	Mar-18	Feb-19
Delphic Core Upgrade	353,886	332,273	Dec-15	Mar-18
Titan Data Warehouse Phase II	397,760	0	Jun-18	Jun-19
Ophthalmology Patient Flow Imp	416,350	405,316	Jul-15	Feb-19
Winscribe Voice Recognition	424,938	345,342	Oct-15	Feb-18
Daily Hospital Functioning	438,700	88,537	Nov-17	Mar-19
eMedicines Reconciliation	450,773	344,650	Jul-15	Dec-18
ImageNet Upgrade	464,038	148,364	Dec-17	Jan-19
IS Stabilisation Phase 1	480,000	480,000	Oct-17	Oct-18
Healthware Upgrade	495,600	102,295	Dec-17	Feb-19
Soprano Medical Docume Upgrade	496,108	166,845	Nov-17	Mar-19
ARPHS Informatics Workplan	496,555	491,818	Jun-17	May-18
PHIMS software platform upgrad	496,555		Dec-16	Jun-18
Tracking System Pathology	562,772	133,810	Oct-14	Feb-19
APS Specimen Tracking	815,005	0	Jun-18	Jun-19
Trendcare Rollout	842,890	715,286	Oct-14	Jun-19
Enterprise Asset Management	955,481	103,544	Mar-18	Jun-19
3M Clinical Record System Upgr	1,284,596	113,417	Oct-17	May-19
CSSD Instrument Tracking	1,317,742	752,373	May-15	Dec-18
Business Objects 4.2 Upgrade	1,845,776	1,654,400	Jan-17	Feb-19
ePrescribing Early Adpopter	1,917,757	1,824,049	Jun-15	Feb-18
IGS0211 Rostering RiTA	2,400,000	2,074,590	Nov-11	Jun-19
healthAlliance Managed Projects - ADHB				

ADHB Rauland Nurse Call – Stage 1 (4934)	\$ 112,068	\$ 60,096	10/12/2016	31/10/2017
ADHB Starship Fibre Resilience (4895)	\$ 114,548	\$ 114,432	12/12/2016	26/10/2017
ADHB Clinical Portal Upgrade – DHB Resource (5374)	\$ 120,000	\$ 120,000	07/04/2018	01/10/2019
ADHB Automated Medication system after hours/ Emergency Medicine cupboard (4426)	\$ 123,000	\$ 123,000	01/08/2016	24/11/2018
ADHB Grafton AED (CDU) Expansion & Redevelopment (4318)	\$ 140,304	\$ 139,522	01/12/2015	01/09/2018
ADHB Scope for Blood Science Work Area (4855)	\$ 159,950	\$ 143,599	08/11/2016	30/06/2018
ADHB Upgrade Cardionavigator Plus (4276)	\$ 168,150	\$ 168,995	18/05/2016	18/08/2018
ADHB Starship Level 5 Redevelopment (4545)	\$ 183,786	\$ 240,877	16/02/2016	18/04/2018
ADHB Prosolv application Upgrade (3421)	\$ 185,736	\$ 222,884	20/08/2013	27/09/2017
ADHB ARPHS Liquor and Alcohol CRM module (4577)	\$ 200,296	\$ 199,589	05/01/2016	03/03/2018
ADHB Datafactory Connectivity to Azure (5370)	\$ 223,120	\$ 20,160	29/03/2018	31/12/2018
ADHB WiFi Coverage Expansion (4955)	\$ 233,000	\$ 231,885	28/02/2017	15/12/2017
ADHB Greenlane AMD Migration (5096)	\$ 234,000	\$ 232,798	04/08/2017	12/06/2018
ADHB CMS 38 (4420)	\$ 240,000	\$ 238,764	21/09/2015	06/10/2017
ADHB WDHB Contact Centre Upgrades FY18/19 (5384)	\$ 255,000	\$ 267,765	24/04/2018	01/12/2018
ADHB WDHB Rightfax Upgrade (2518)	\$ 293,089	\$ 287,494	29/03/2016	08/06/2018
ADHB CMS 39 (4423)	\$ 324,983	\$ 324,514	09/01/2017	27/06/2018
ADHB Datix Software Solution to Replace Risk Monitor and Feedback Monitor Pro (4288)	\$ 337,495	\$ 280,418	22/03/2016	14/02/2018
ADHB CMS 40 (5265)	\$ 339,772	\$ 84,772	30/11/2017	01/03/2019
ADHB WiFi Coverage Expansion FY1718 (5074)	\$ 361,000	\$ 347,381	29/06/2017	01/10/2018
ADHB WDHB Contact Centre Solution Fault Remediation (5099)	\$ 370,000	\$ 368,799	18/07/2017	08/06/2018
ADHB Upgrade HCC Diabetes (4407)	\$ 417,322	\$ 407,294	03/08/2015	29/06/2018
ADHB Haemodynamic Monitoring System (4680)	\$ 425,651	\$ 289,127	03/10/2016	04/07/2018

ADHB & NDHB Clinical Portal Upgrade (5269)	\$ 435,595	\$ 324,688	28/03/2017	01/02/2020
ADHB Upgrade HCC Community Sexual Health(4299)	\$ 441,718	\$ 436,427	19/01/2015	28/02/2018
ADHB Tier 1 Hub Room Upgrade (5081)	\$ 455,000	\$ 430,431	03/07/2017	27/07/2018
ADHB Infection Prevention and Control System (ICNET) (3852)	\$ 499,964	\$ 499,947	24/02/2015	29/06/2018
ADHB Titanium V 52 to V 76 Upgrade (4463)	\$ 532,250	\$ 531,801	16/10/2015	12/07/2017
ADHB Linear Accelerator Replacement (4529)	\$ 533,843	\$ 389,072	09/01/2017	27/04/2018
ADHB Security Upgrade – Hub Rooms (4391)	\$ 832,000	\$ 776,640	02/08/2015	21/06/2018
ADHB Metro PACS Upgrade (4405)	\$ 855,103	\$ 852,668	27/11/2014	28/07/2018
ADHB Security Upgrade – Servers and Storage (4392)	\$ 900,000	\$ 634,575	01/07/2015	15/03/2018
Metro and ADHB Leader Kiosk Upgrade (4854)	\$ 1,250,012	\$ 935,612	07/11/2016	28/09/2018
healthAlliance Managed Projects - Regional				
Regional Desktop Power Savings Implementation (4965)	\$ 105,000	\$ 105,000	13/03/2017	04/10/2018
Regional Wi-Fi Trusted Access (4936)	\$ 116,000	\$ 116,000	13/02/2017	28/07/2018
Regional Oracle EBS Platform Stabilisation (5404)	\$ 120,000	\$ 120,000	02/05/2018	01/04/2019
Regional Directory Remediation – Certificate Services (4941)	\$ 122,334	\$ 122,334	18/02/2017	28/09/2018
Regional ISSP EA Integration Design (5152)	\$ 140,000	\$ 140,000	08/06/2017	04/09/2017
Regional SQL Legacy Database Migration (4920)	\$ 145,750	\$ 145,750	16/01/2017	30/12/2018
Regional Cyber - Security Governance (5093)	\$ 150,000	\$ 150,000	02/07/2017	29/06/2018
Regional Cyber Plan – Security Standards FY1617 (4845)	\$ 150,000	\$ 150,000	25/10/2016	25/10/2017
Regional Enhanced Print Device Management (4759)	\$ 150,000	\$ 150,000	09/08/2016	13/12/2017
Regional Minor Environmental Upgrades (5112)	\$ 150,000	\$ 150,000	24/07/2017	01/07/2018
Regional Self-service Reset for Windows Domain User Account Password (4852)	\$ 155,120	\$ 155,120	02/11/2016	30/06/2018

Regional Core Firewall Refresh (4977)	\$ 155,139	\$ 155,139	04/04/2017	29/06/2018
Regional Information Security Planning (4675)	\$ 158,000	\$ 158,000	07/06/2016	12/10/2017
Regional Capacity Management Plan (5149)	\$ 160,000	\$ 160,000	15/02/2018	30/09/2018
Regional Storage Tier 1 Growth - Disks (5160)	\$ 173,000	\$ 173,000	02/08/2017	16/03/2018
Regional VMware Farm ESX Capacity Expansion (4925)	\$ 185,000	\$ 185,000	02/11/2016	11/08/2017
Regional Wannacry Response (5058)	\$ 195,000	\$ 195,000	01/05/2017	31/07/2017
Regional Cyber - Privileged Account Mgmt (5143)	\$ 200,000	\$ 200,000	02/11/2017	30/11/2018
Regional Microsoft License Review (G2018) (5267)	\$ 205,000	\$ 205,000	07/11/2017	01/09/2018
Regional Directory Remediation SAH & WHL (4915)	\$ 209,000	\$ 209,000	23/01/2017	30/06/2018
Regional Internet Access Consolidation (4792)	\$ 211,476	\$ 211,476	12/07/2016	06/10/2018
Regional SpectrumScale Backup (5383)	\$ 217,000	\$ 217,000	18/04/2018	01/10/2018
Regional Cyber - GCIO Ext Web sites - Balance (5146)	\$ 220,000	\$ 220,000	31/08/2017	13/12/2018
Regional Cyber - Server Anti Malware (5024)	\$ 220,000	\$ 220,000	24/05/2017	25/06/2018
Regional Exchange Remediation (5076)	\$ 220,390	\$ 220,390	02/08/2017	16/12/2018
Regional Cluster Review (5177)	\$ 225,000	\$ 225,000	12/09/2017	01/09/2018
Regional MAS Risk Mitigation (4752)	\$ 225,000	\$ 225,000	10/08/2016	26/01/2018
19254 - Reg Enterprise Arch - Design Intergration (5140)	\$ 230,000	\$ 230,000	02/08/2017	04/09/2017
Regional SAN Volume Controller Remediation (5284)	\$ 235,000	\$ 235,000	27/11/2017	21/06/2018
Regional XenMobile Resilience (5010)	\$ 236,151	\$ 236,151	01/05/2017	31/08/2017
Regional Cyber – Virtual Patch Server Fleet (5019)	\$ 250,000	\$ 250,000	24/05/2017	03/07/2017
Regional Cyber Server Patching Q3-4 FY1617 (4917)	\$ 250,000	\$ 250,000	17/01/2017	31/10/2017
Regional Hub Room UPS Remediation (5283)	\$ 250,000	\$ 250,000	04/12/2017	21/07/2018
Regional Facilities Monitoring and Alerting ADHB NDHB (5079)	\$ 250,000	\$ 250,000	15/07/2017	26/06/2018
Regional ISSP Information Management Capability - Establish	\$ 252,600	\$ 252,600	17/10/2017	05/07/2018

(5150)				
Regional Virtual Server Resource Recovery (4961)	\$ 260,000	\$ 260,000	01/03/2017	28/07/2018
Regional Computer Room Remediation 17/18 (5326)	\$ 264,340	\$ 264,340	02/02/2018	01/08/2018
Regional DTaaS – Workload Assessment & Migration Evaluation (5376)	\$ 271,216	\$ 271,216	02/05/2018	30/06/2018
Regional ISSP Enterprise Architecture – Phase 2 (5307)	\$ 271,568	\$ 271,568	08/01/2018	01/07/2018
Regional Telehealth Project (4760)	\$ 272,707	\$ 272,707	13/08/2016	31/08/2018
Regional DTaaS - TaaS Secondary Procurement (5335)	\$ 282,689	\$ 282,689	01/03/2018	01/07/2018
Regional ISSP EA Tools Implementation (5101)	\$ 293,111	\$ 293,111	04/07/2017	29/06/2018
Regional Paging Transition - Tactical (5049)	\$ 294,000	\$ 294,000	20/05/2017	26/01/2018
Regional Cyber - Vulnerability Management (5127)	\$ 300,000	\$ 300,000	05/06/2017	01/11/2018
Regional Exadata Migration and Decommissioning (5090)	\$ 300,000	\$ 300,000	03/07/2017	31/08/2018
Regional XaaS hA Target Operating Model (5148)	\$ 300,000	\$ 300,000	02/07/2017	01/07/2018
Regional Hub Room Remediation FY1617 (4712)	\$ 301,924	\$ 301,924	04/07/2016	21/08/2017
Regional ISSP APM Implementation (5100)	\$ 318,000	\$ 318,000	02/02/2017	29/06/2018
Regional ISSP – BI and Analytics Strategy (5217)	\$ 320,401	\$ 320,401	01/02/2018	29/06/2018
Regional SQL Server Reporting Services 2014 (4888)	\$ 327,000	\$ 327,000	28/01/2017	31/12/2018
Regional LAN Switch Replacement FY1617 (4751)	\$ 328,000	\$ 328,000	08/08/2016	19/07/2017
Regional One Network Phase 3 exit from Galbraith (4516)	\$ 329,020	\$ 329,020	08/12/2015	27/11/2017
Regional Cyber - Securing OWA (4869)	\$ 330,000	\$ 330,000	19/11/2016	10/08/2018
Regional WiFi Network Expansion – Resilience and Performance (4848)	\$ 330,000	\$ 330,000	02/10/2016	19/07/2017
Regional Server Switch Replacement - Grafton (4939)	\$ 336,000	\$ 336,000	13/02/2017	27/07/2018
Regional Network Hub Room Upgrades (ADHB) (5485)	\$ 350,717	\$ 350,717	02/07/2018	01/07/2019
Regional ISSP Devices, Channel and Workspace Strategy (5153)	\$ 351,000	\$ 351,000	02/07/2017	01/07/2018

Regional DTaaS – Detailed Design Planning/Mobilisation (5211)	\$ 364,840	\$ 364,840	02/10/2017	29/06/2018
Regional P2V Phase 4 (4957)	\$ 365,000	\$ 365,000	24/02/2017	12/06/2018
Regional ISSP Data Information Strategy & Architecture(5151)	\$ 370,000	\$ 370,000	02/07/2017	29/06/2018
Regional Cyber Baseline Server Fleet Vulnerability (5050)	\$ 375,000	\$ 375,000	03/07/2017	31/10/2017
Regional Network Grafton CORE card replacement (4953)	\$ 379,577	\$ 379,577	05/05/2017	05/07/2018
Regional Middlemore Tier2 Storage Growth (4907)	\$ 389,000	\$ 389,000	13/12/2016	30/11/2017
Regional Backup Expansion (5097)	\$ 392,460	\$ 392,460	07/07/2017	21/07/2018
Regional Cyber - Network Inspection (5013)	\$ 395,000	\$ 395,000	03/06/2017	01/09/2018
Regional Disk Backup Appliance - Grafton (4983)	\$ 399,952	\$ 399,952	27/03/2017	29/06/2018
Regional Server Patching (Cycle 1 & 2) (5467)	\$ 400,000	\$ 400,000	12/06/2018	01/01/2019
Regional Cyber - Mobility Threat Management (5161)	\$ 400,000	\$ 400,000	28/08/2017	28/09/2018
Regional Cyber - Policy and Standard Development (5094)	\$ 400,000	\$ 400,000	02/08/2017	29/06/2018
Regional UPS Hardware Replacement Feb16 (4670)	\$ 400,000	\$ 400,000	02/02/2016	19/07/2017
Regional Network Hub Room Upgrades (CMDHB) (5473)	\$ 402,000	\$ 402,000	02/07/2018	29/06/2019
Regional Paging Service Replacement (4553)	\$ 402,000	\$ 402,000	01/03/2016	29/06/2018
Regional Exadata Upgrade – MMH Dev (4554)	\$ 403,567	\$ 403,567	02/03/2016	29/06/2018
Regional Internet Optimisation (2627)	\$ 410,000	\$ 410,000	05/06/2013	31/01/2018
Regional Exadata Upgrade – Middlemore (4738)	\$ 410,135	\$ 410,135	02/03/2016	29/06/2018
Regional ISSP Programme Management – Phase 2 (5304)	\$ 415,339	\$ 415,339	08/01/2018	29/06/2018
Regional HealthSafe Digital Foundations (4979)	\$ 415,718	\$ 415,718	22/03/2017	30/06/2018
Regional Legacy WAN services replacement (4926)	\$ 416,000	\$ 416,000	23/01/2017	30/06/2018
Regional PABX Risk Mitigation - Regional Telephony Resiliency (5008)	\$ 421,730	\$ 421,730	06/06/2017	21/06/2018
Regional Data Centre as a Service (DCaaS) - IBC (5068)	\$ 422,500	\$ 422,500	01/06/2017	01/12/2017
Regional Bitlocker Deployment (3956)	\$	\$	26/08/2014	25/08/2018

	425,000	425,000		
Regional Desktop Replacement FY1718 – 4th Stage (5282)	\$ 449,000	\$ 449,000	02/12/2017	30/06/2018
Regional Compute Capacity - Grafton (5366)	\$ 450,000	\$ 450,000	12/03/2018	30/06/2018
Regional Compute Capacity – Middlemore (5367)	\$ 450,000	\$ 450,000	12/03/2018	30/06/2018
Regional Security Assessment Capability (5482)	\$ 450,000	\$ 450,000	02/07/2018	29/06/2019
Regional Dial Plan - CMH and ADHB (5078)	\$ 453,010	\$ 453,010	21/07/2017	01/06/2018
Regional Monitoring & Discovery FY1617 (4919)	\$ 456,000	\$ 456,000	31/01/2017	14/07/2018
Regional DTaaS Gateway Review and Governance sign off (5087)	\$ 460,491	\$ 460,491	01/08/2017	23/02/2018
Regional DTaaS – Detail Transition Planning (5377)	\$ 463,980	\$ 463,980	01/05/2018	01/11/2018
Regional ISSP Applications Roadmap – Phase 1 (5155)	\$ 468,158	\$ 468,158	16/08/2017	23/05/2018
Regional Computer Room Remediation (4987)	\$ 473,000	\$ 473,000	11/04/2017	04/07/2018
Regional Desktop Replacement FY1718 - 5th Stage (5310)	\$ 480,000	\$ 480,000	01/03/2018	30/06/2018
Regional Dialling Plan FY16/17 (4863)	\$ 480,500	\$ 480,500	07/11/2016	05/02/2018
Regional MAS Replacement Capacity Growth (5025)	\$ 480,601	\$ 480,601	01/06/2017	21/07/2017
Regional ISSP 2.0 Programme Management - Establish (5060)	\$ 481,700	\$ 481,700	03/07/2017	23/05/2018
Regional Network Attached Storage (NAS) Solution (4799)	\$ 485,218	\$ 485,218	25/08/2016	26/01/2018
Regional Grafton Tier2 Storage Growth (4908)	\$ 486,338	\$ 486,338	13/12/2016	30/11/2017
Regional ISSP APM Operationalisation (5154)	\$ 489,000	\$ 489,000	02/04/2018	01/11/2018
Regional ISSP Applications Roadmap – Phase 2 (5287)	\$ 489,972	\$ 489,972	08/01/2018	30/06/2018
Regional Cyber - Advanced Threat Management (5037)	\$ 490,000	\$ 490,000	02/07/2017	01/11/2018
Regional OSR WS2003 Mitigation (4612)	\$ 490,000	\$ 490,000	02/05/2016	09/01/2018
Regional Directory Services Remediation (4416)	\$ 492,472	\$ 492,472	14/09/2015	09/01/2018
Regional ISSP Enterprise Architecture - Establish (5063)	\$ 494,300	\$ 494,300	03/07/2017	01/04/2018
Regional Tier 1 Grafton Storage Growth (5033)	\$ 495,000	\$ 495,000	02/06/2017	16/03/2018

Regional Exadata Upgrade – Grafton (4737)	\$ 497,573	\$ 497,573	02/03/2016	29/06/2018
Regional Citrix Growth and Stability (4867)	\$ 497,594	\$ 497,594	04/10/2016	22/09/2017
Regional Identity and Access Management (IAM) Strategy (5312)	\$ 499,000	\$ 499,000	03/10/2017	31/07/2018
Regional Network Hub room upgrades (NDHB) (5474)	\$ 499,400	\$ 499,400	02/07/2018	29/06/2019
Regional C1C2 SQL 2014 Platform (4740)	\$ 499,577	\$ 499,577	09/08/2016	16/08/2017
Regional DTaaS - TaaS RFP (5293)	\$ 499,914	\$ 499,914	01/01/2018	30/04/2018
Regional Identity & Access Management Strategy (5030)	\$ 502,676	\$ 502,676	12/06/2017	01/07/2018
Regional Support for the ADHB-WDHB Contact Centre Collaboration Project initiative (3711)	\$ 634,300	\$ 634,300	25/10/2013	04/12/2017
Regional Tier 1 MMH XIV Gen2 Storage Replacement (4929)	\$ 850,000	\$ 850,000	25/10/2016	12/06/2018
Regional Upgrade Desktop Browser to IE11 (4240)	\$ 1,376,871	\$ 1,376,871	02/07/2015	31/07/2017
Regional EMM platform (4523)	\$ 2,385,000	\$ 2,385,000	22/12/2015	06/07/2017
Regional Desktop Replacement FY1617 (4781)	\$ 3,150,000	\$ 3,150,000	01/09/2016	28/07/2017
Regional Compute Storage Refresh and Expansion (4492)	\$ 3,405,169	\$ 3,405,169	02/10/2015	17/07/2017
Regional Wi-Fi deployment across DHB sites (3806)	\$ 4,126,824	\$ 4,126,824	17/02/2014	31/07/2017
Regional ISSP Workspace Business Case (5135)	\$ 4,950,002	\$ 4,950,002	13/11/2017	01/07/2021
Regional Integration Engine (IEP) Programme (ESB/JCAPS replacement) (4841)	\$ 10,593,644	\$ 10,593,644	09/03/2017	29/03/2019
Regional XenMobile Resilience (5010)	209,676.35		May-17	May-17

Question 323 – Appendix 1

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance



19 DEC 2018

Mr Pat Snedden
Chair
Auckland District Health Board
patsnedden@adhb.govt.nz

Dear Pat

Letter of Expectations for district health boards and subsidiary entities for 2019/20

This letter sets out the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2019/20.

In early September, the Prime Minister announced a long-term plan to build a modern and fairer New Zealand; one that New Zealanders can be proud of. As part of the plan, our Government commits to improving the wellbeing of all New Zealanders and their families, and ensuring that the economy is growing and working for all.

Our health system has an important role in supporting the Government's goals. To do this we need to be sure that our public health system is: strong and equitable, performing well, and focused on the right things to make all New Zealanders' lives better.

Achieving equity within the New Zealand health system underpins all of my priorities. Māori as a population group experience the poorest health outcomes. As you consider equity within your district, there needs to be an explicit focus on achieving equity for Māori across their life course. Māori-Crown relations is a priority for this Government and I expect your DHB to meet your Treaty of Waitangi obligations as specified in the New Zealand Public Health and Disability Act 2000. I am expecting you to report on progress with how you are meeting these obligations as part of your Annual Plan reporting.

Unmet need also represents a significant barrier to achieving equity in health outcomes for all populations groups across New Zealand. I expect your Annual Plan to contain actions that will enable progress towards achieving equity and to address the key areas of unmet need especially for Pacific peoples and other population groups in your regions with poorer health outcomes.

Our approach

DHB Chairs are directly accountable for their DHB's performance. We expect Boards to be highly engaged and to hold Chief Executives and management to account for improved performance within their DHB, in relation to both equity of access to health services and equity of health outcomes. In addition, I will also be working towards ensuring that Māori membership of DHB Boards is proportional to the Māori population within your district.

Fiscal responsibility

Strong fiscal management is essential to enable delivery of better services and outcomes for New Zealanders. I expect DHBs to live within their means and maintain expenditure growth in line with or lower than funding increases.

My expectation is that DHBs have in place clear processes to ensure appropriate skill mix and FTE growth that supports changes in models of care and use the full range of the available workforce and settings. This is essential for ensuring financial and clinical sustainability of our health system.

A better collective understanding of the demand for services, drivers of deficits and financial risks remains a very significant priority and I expect you to work closely and proactively with the Ministry of Health on these matters. I will continue to meet and speak with you frequently during the year to discuss performance, and I will be looking particularly closely at your ability to deliver in the Government's priority areas, to keep within budget and to manage your cash position.

Strong and equitable public health and disability system

Building infrastructure

My expectation is for timely delivery of Ministers' prioritised business cases. I remind you that capital projects over \$10 million are subject to joint Ministers (Minister of Health and Minister of Finance) approval. Business cases will be assessed to ensure that they are in line with the Health Capital Envelope priorities. I also expect you ensure that your agency is aware of the expectation that upcoming construction projects will be used to develop skills and training and that the construction guidelines will be applied for all procurement of new construction from this point onwards. I will be writing to you separately about this with further detail.

National Asset Management Plan

I expect you to support the National Asset Management Plan programme of work. I encourage you to actively interact with the project as, long term, the National Asset Management Plan will formulate the capital investment pipeline, and ensure DHBs' future infrastructure needs are met.

Devolution

I am considering devolution of certain services and expect to be making decisions in the New Year. DHBs will be consulted during the process to ensure the financial and service implications are well understood. Once any decisions have been made, I will expect you to work with the Ministry of Health to ensure a seamless transition of responsibilities.

Workforce

I expect DHBs to develop bargaining strategies that are consistent with the Government Expectations on Employment Relations in the State Sector, and to act collaboratively to ensure that any potential flow-on implications across workforces and/or across DHBs are understood and addressed in the bargaining strategies. A Government priority is raising the wages of the least well-paid workforces, which will require a different approach to the traditional one based on across-the-board percentage increases. I also expect DHBs to implement Care Capacity Demand Management in accordance with the process and timetable set out in the 2018-2020 MECA. I note that the State Services Commissioner has included wording that reflects the commitments in the New Zealand Nurses Organisation Accord in the performance expectations of the Director-General of Health and I ask you to consider including similar wording in the performance expectations of your Chief Executive.

DHBs have an essential role in training our future workforce and I expect you to support training opportunities for the range of workforce groups. As part of this, you should work closely with training bodies such as tertiary education institutes and professional colleges and bodies to ensure that we have a well trained workforce and to support research. I continue to expect DHBs will adhere to the Medical Council's requirement for community-based attachments for PGY1 and PGY2 doctors.

Bowel Screening

The National Bowel Screening programme remains a priority for this Government, and I expect you to develop a sustainable endoscopy workforce, be it medical or nursing, including the strategic support of training positions for both nursing and medical trainees in order to meet growing demand in this area. It is crucial that symptomatic patients are not negatively impacted by screening demand and the Ministry of Health will work closely with you on workforce issues to support this.

Planned Care

I am enabling DHBs to take a refreshed approach to the delivery of elective services under a broader "Planned Care" programme. Timely access to Planned Care remains a priority. The refreshed approach to Planned Care will provide you with greater flexibility in where and how you deliver services and will enable more care to be delivered within the funding envelope. I urge you to take advantage of the opportunity that will be made available, and support your teams to develop well considered delivery plans that align with your population's needs, support timely care, and make the best use of your workforce and resources.

Disability

Disabled people experience significant health inequalities and they should be able to access the same range of health services as the rest of the general population. My expectation is that DHBs are working towards or are implementing the Convention on the Rights of Persons with Disabilities. I expect DHBs to implement policies for collecting information, within their populations, about people with disabilities. In addition, please ensure your contracts with providers reflect their requirements to either ensure accessibility or put in place concrete plans to transition to a more accessible service.

System Level Measures

As part of your focus on improving quality, I expect you to continue to co-design and deliver initiatives to achieve progress on System Level Measures with primary health organisations (PHOs) and other key stakeholders.

Rural health

The Government expects DHBs with rural communities to consider their health needs and the factors affecting health outcomes for rural populations when making decisions regarding health services.

Mental health and addiction care

Mental health and addiction remains a priority area for this Government and I expect your DHB to prioritise strengthening and improving mental health and addiction service areas in your 2019/20 Annual Plan. The Mental Health and Addiction Inquiry report is under consideration by the Government and it is my expectation that DHBs are ready to move on implementing the Government's response to its recommendations.

Over the last year a number of deaths across the country have been attributed to use of synthetic cannabinoids. I expect DHBs to consider the role of both public health and specialist treatment services in providing coordinated local responses to emerging drug threats such as synthetic cannabinoids.

Child wellbeing

Child wellbeing is a priority for our Government. I expect your annual plans to reflect how you are actively working to improve the health and wellbeing of infants, children, young people and their whānau with a particular focus on improving equity of outcomes.

In supporting the Government's vision of making New Zealand the best place in the world to be as a child I expect DHBs to have a specific focus on:

- supporting the development of the Child Wellbeing Strategy, particularly the First 1000 days of a child's life and child and youth mental wellbeing
- contributing to the review of the Well Child Tamariki Ora programme
- supporting the reduction of family violence and sexual violence through addressing abuse as a fundamental health care responsibility.

Maternity care and midwifery

High quality maternity care is recognised as a fundamental part of child wellbeing. I am listening to the issues the community is raising with me, and I take the concerns about the level of capacity in the midwifery workforce seriously. It is my expectation that DHBs implement a plan to support improved recruitment and retention of midwives, including midwives in the community and midwives employed in all maternity facilities.

Smokefree 2025

I also expect you to advance progress towards the Smokefree 2025 goal, particularly community-based wrap-around support for people who want to stop smoking, with a focus on Māori, Pacific, pregnant women and people on a low income. I also want to see DHBs collaborating across their region to support smoking cessation including, where appropriate, amongst programme providers, with a view to sharing and strengthening knowledge and delivery of effective interventions.

Primary health care

Improved access to primary health care brings significant benefits for all New Zealanders as well as our health system. Removing barriers to primary health care services and improving equity are key priorities for this Government. I also want to see closer integration of primary health care with secondary and community care. I intend to continue to invest in primary health care and expect all DHBs to support this important priority.

Non-communicable disease (NCD) prevention and management

As our major killers, NCDs, particular cancers, cardiovascular disease and type 2 diabetes need to be a major focus for prevention and treatment for your DHB. I want you to continue a particular focus on type 2 diabetes prevention and management, including an emphasis on ensuring access to effective self-management education and support. I want to see an increased focus on prevention, resilience, recovery and wellbeing for all ages, as part of a healthy ageing approach. You should also use PHO and practice-level data to inform quality improvement.

Public health and the environment

Environmental sustainability

I expect you to continue to contribute to the Government's priority outcome of environmental sustainability and undertake further work that leads to specific actions, including reducing

carbon emissions, to address the impacts of climate change on health. This will need to incorporate both mitigation and adaption strategies, underpinned by cost-benefit analysis of co-benefits and financial savings and I expect you to work collectively with the Ministry of Health on this important area.

Healthy eating and healthy weight

As part of your sector leadership role, I strongly encourage you to support healthy eating and healthy weight through continuing to strengthen your DHB's Healthy Food and Drink Policy. This includes increasing the number of food options categorised as 'green' in the National Policy and moving towards only selling water and milk as cold drink options. I actively encourage you to support other public and private organisations to do the same. There is a strong rationale for DHBs providing such leadership in their communities to both set an example and to 'normalise' healthy food and drink options. In particular I would like you to work directly with schools to support them to adopt water-only and healthy food policies.

Drinking water

You will be aware that our Government is undertaking system-wide reform of the regulatory arrangements for drinking water and I am confident that you will support any developments that may result. I expect you to work through your Public Health Unit across agency and legislative boundaries to carry out your key role in drinking water safety with a focus on the health of your population.

Integration

Improving equity and wellbeing and delivering on several other expectations I am setting in this letter will not be possible without strong cross-sectoral collaboration. I expect DHBs to demonstrate leadership in the collaboration between and integration of health and social services, especially housing.

Planning processes

Your DHB's 2019/20 Annual Plan is to reflect my expectations and I also ask you to demonstrate a renewed focus on your strategic direction, by refreshing your Statement of Intent in 2019/20.

I believe providing you with my expectations in December will support your planning processes, however I also acknowledge that some important decisions will be made in the coming weeks, including detail related to implementation of the Mental Health and Addictions Inquiry recommendations. To ensure my expectations are clear, it is my intention to provide an update to this letter in the New Year.

I would like to take this opportunity to thank you, the Board and your staff for your dedication and efforts to provide high quality and equitable outcomes for your population.

Yours sincerely



Hon Dr David Clark
Minister of Health